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Santénet Annual Report

October 2004 to September 2005

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ACRONYMS

ACT	Artemisinin-based Combination Therapy
ADRA	Adventist Development and Relief Agency
ANC	Antenatal consultations
ARI	Acute Respiratory Infections
CBD	Community-based distribution
CBDA	Community-based distribution agents
CBHC	Community-based Health Center
CCM	Country Coordinating Mechanism
CNLP	National Malaria Control Policy CNLP
CPR	Condom prevalence rate
DHS	Demographic Health Survey
DQS	Data Quality Self-Assessment
EMAD	District Management Team
EMC	Essential Medical Coverage
ENA	Essential Nutrition Actions
EONC	Emergency Obstetrical and Neonatal Care
EPI	Expanded Program on Immunization
ES/NACC	Executive Secretariat of the National AIDS Control Committee
FHD	Family Health Division
FP/RH	Family Planning/Reproductive Health
FPC	Focused Prenatal Care
FPC/PMP	Focused Prenatal Care/Prevention of Malaria During Pregnancy
GED	Generic Essential Drugs
GOM	Government of Madagascar
GTZ	German Technical Cooperation Agency
HCMC	Health Communication and Mobilization Committee
HCP	Health Communication Partnership
HMIS	Health Information and Management System
IACC	EPI Inter-Agency Coordination Committee
IEC/BCC	Information Education Communication/Behavior Change Communication
IECSMU	IEC and Social Mobilization Unit
IECSMU	MOH/FP's IEC and Social Mobilization Unit
IHAA	International HIV/AIDS Alliance
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Presumptive Treatment

IR	Intermediate Result
IRH	Institute for Reproductive Health
ITN	Insecticide-Treated Nets
KM	*Kôminina Mendrika* (Champion Commune)
LTPM	Long-Term Permanent Methods
MAC	Malaria Coalition Action Project
MAR	Monthly Activity Report
MCU	MOH/FP's Malaria Control Unit
MIS	Management Information System
MOH/DHS	District Health Services
MOH/FP	Ministry of Health and Family Planning
NCHP	National Child Health Policy
NCPH	National Contracting Policy for Health
NGO	Non Governmental Organizations
NHP	National Health Policy
NIPCH	National Institute of Public and Community Health
NNAP	National Nutrition Action Plan
NNO	National Nutrition Office
NNP	National Nutrition Policy
PMP	Performance Monitoring Plan
PNP	Protocols, Norms and Procedures
PQI	Performance and Quality Improvement
PSI	Population Services International
PTI	Para-medical Training Institution
RBM	Roll Back Malaria
RDT	Rapid Diagnosis Test
RED	Reach Every District
RHD	Regional Health Directorate
SDM	Standard Days Method
SM	Safe Motherhood
SP	Sulfadoxine pyrimethamine
STI	Sexually-Transmitted Infection
TOT	Training of Trainers
WHO	World Health Organization

EXECUTIVE SUMMARY

Since 1962, USAID/Madagascar has contributed to the economic and social development in Madagascar. The goal of the FY 2003–2008 Integrated Strategic Plan is "Sustainable and Inclusive Economic Development," which highlights the need for integrated, transformational and sustainable development that benefits all segments of Malagasy society.

USAID's strategic objectives will improve good governance, protect biologically diverse forest ecosystems, expand and strengthen critical private markets, and increase the use and improve the quality of selected health products and services. USAID's long-term commitment to improving health status in Madagascar is embodied by the Santénet project, which represents the third phase of USAID's assistance to the Government of Madagascar to improve the health and the well-being of the Malagasy population, preceded by APPROPOP (1993–1998) and Jereo Salama Isika (1999–2003).

Santénet assists the MOH/FP by focusing its activities on USAID's four intermediate results:

1. Increasing the Demand for Health Products and Services
2. Increasing the Availability of Health Products and Services
3. Improving the Quality of Services Provided
4. Strengthening Institutional Capacities

In its first year of operations, Santénet has laid the foundation for much of its future work: conceptualizing and launching the *Kôminina Mendrika* approach to community mobilization that increases demand and support to health, introducing the Performance and Quality Improvement (PQI) initiative to improve quality of service provision at basic health centers (BHC), and developing productive relationships of trust and respect with key partners in the public and private sectors – especially within the Ministry of Health and Family Planning (MOH/FP) – to create a policy environment favorable to the project's goals, including the increase in access to health services and building of local capacity.

By building on previous USAID success and adapting proven approaches to speed implementation and impact, Santénet has completed its first year of implementation with notable successes. Demonstrating the effectiveness of Santénet's approaches, the project has leveraged funds from other sectors and other donors, which will multiply the project's impact and represents important cost effectiveness.

In terms of project operations, Santénet successfully set up the project office (including all administrative systems) and fielded key staff, continuing apace throughout the year in its equipping and staffing of four regional offices. During its first year, Santénet met the terms of the contract for deliverables by submitting its semiannual progress report, its Year 2 implementation plan, the project performance monitoring plan, and monthly financial reporting requirements.

Building upon the work and success of its first year, Santénet is poised to continue its success during the second year of implementation.

Santénet's first annual report is structured as follows: The first two chapters provide an introduction to the

project's context and the project itself. Chapters Three through Seven detail the important activities conducted in the first year, categorized by Intermediate Results, and also provides an analysis of the larger health impact achieved. Success stories from the projects are interspersed in these chapters, along with anecdotal information about regional activities, which provide more detailed examples of how the project's activities are implemented in the field. Chapter Eight provides a summary table of the project's progress against the objectives, indicators and benchmarks established in the project monitoring plan. Chapter Nine describes the achievements in program management and administration, including Santénet Fund's operations. Chapter Ten analyzes Santénet's first year to propose some best practices and lessons learned that will inform future programming. Chapter Eleven outlines Santénet's planned activities for its second year. The Annual Report's Annexes provide more detail.

Highlights of Santénet's achievements for 2004-2005 include:

At the national level, Sanénet has strengthened the leadership of the Ministry of Health and Family Planning (MOH/FP) and the collaboration amongst all the actors working in health education and community mobilization activities to ***increase demand for health products and services*** under IR1. In its first year, Santénet:

Helped to establish the Health Communication and Mobilization Committee (HCMC): With Santénet's assistance, the IEC and Social Mobilization Unit (IECSMU) under MOH guidance drafted the HCMC terms of reference, defined standard operating procedures and set up three technical sub-committees.

Assisted in developing the National Family Planning Communication Strategy: Under the Family Health sub-committee of the IECSMU, the MOH prioritized the development of the National Family Planning Communication Strategy. While the strategy is scheduled to be finalized in March of 2006, Santénet and the Health Communication Partnership (HCP) have assisted the sub-committee in developing an interim strategy to keep FP in the public consciousness.

At the community level, Santénet has:

Introduced the *Kôminina Mendrika* (KM) approach: This approach to community mobilization is based on scaling up and expanding coverage, using KM as a multisectoral platform for all sectors of development by building the capacity of local entities. The first year of KM targets 81 communes, and has seen the development of a number of support tools and a series of trainings for local support technicians and local government officials to introduce the approach and provide the skills necessary for its effective implementation.

Adapted A*nkoay* HIV/AIDS prevention methodology: This approach gathers the members of the scouting federation to promote youth leadership in HIV/AIDS activities. Currently, 100 scout troops in nine regions of Madagascar have been trained using *Ankoay*. The SE/CNLS has approved the *Ankoay* methodology and has increasingly adopted the approach for youth-targeted interventions.

To ***increase the availability of health products and services*** access, Santénet provided support to the MOH/FP to create a policy environment and institutional structures that encourage technically sound health policies and activities. This year, Santénet:

Helped to integrate contraceptives into the medical supply chain: Santénet facilitated the introduction of a new training curriculum targeting health district SR/PF managers. A tool to evaluate health district integration was developed and used. The results of this evaluation identify specific actions for each health district to improve their performance.

Supported the repositioning of family planning (FP): With technical and financial support from Santénet, preliminary workshops were organized, followed by national conference in December 2004, led by the President of the Republic. This series of activities involved over 500 people and resulted in the adoption of a new FP strategy.

Helped MOH/FP expand basic medical coverage: Santénet provided technical assistance to the MOH/FP for the launch of the Equity Fund. In addition, Santénet has assisted in gathering lessons learned from community-based health financing

schemes, known as *mutuelles,* to support its expansion as a mechanism to reduce economic barriers to health care.

National Condom Programing Strategy. Santénet recruited two international consultants to help operationalize the strategy by identifying supply networks and IEC/BCC strategies. Taking action from the practical recommendations by these experts, the SE/CNLS is currently operationalizing the distribution logistics and carries out activities aiming at increasing demand to 15 million condoms for this year. With technical assistance from Santénet, the supply network was validated at the national level and a training curriculum was developed.

Santénet has worked at the national and at the service provision levels to ***improve the quality of services***. In its first year, Santénet:

Helped to improve policies, norms and protocols: Santénet has assisted the MOH/FP revise and revamp policies, standards and protocols, including the National Policy on Child Health and the National Health Training Policy, prevention of malaria during pregnancy (PMP) protocols, and revision of RH/FP National Standards and Protocols.

Assisted in improving infection prevention (IP) practices: With the MOH/FP, Santénet assessed IP practices in 11 sites. In response to the finding, training workshops were undertaken with 98 people trained in IP practices. Santénet then assisted the MOH/FP in monitoring IP practices at training sites.

Introduced the Standard Days Method (SDM)of natural family planning: To expand the range of FP methods available in Madagascar, Santénet assessed the acceptability of SDM in collaboration with the MOH/FP, and other faith-based partners. To date, 26 sites are delivering SDM.

Introduced the Performance and Quality Improvement (PQI) approach for training sites and the KM BHCs: This process represents Santénet's major strategy for improving quality of service delivery. While this is a continuing activity, in the first year, desired national performance standards for FP, HIV/AIDS/STIs and PMP were defined through a participatory process. After analyzing the feasibility of integrating PQI into the *Kôminina Mendrika* communes, plans have been developed to realize this activity in the coming year.

Working to **strengthen institutional capacities** at the national level, as well as with NGOs and the private section, Santénet:

Assessed the Health Information and Management System (HMIS): With support from Santénet, the MOH evaluated HMIS performance and updated the HMIS tools. MOH/FP officials, with Santénet's support, organized workshops to update data use, harmonize routine and punctual data collection, and develop a national HMIS policy. A total of 241 participants from the MOH/FP departments, representatives of private entities and of the national and international partners participated.

Initiated the use of the Chartbook as a data management tool: Santénet supported the MOH/FP to design analytical tools to ensure local health decision making was evidence-based. The Chartbook allows BHC managers and community leaders to effectively collect and analyze data and to make appropriate decisions regarding health activities.

Strengthened NGO capacity through competitive awards process: Santénet strengthened NGO organizational capacity through the use of the Santénet Fund, which required them to submit proposals for the implementation of KM, to then respond to technical and financial questions from Santénet, to negotiate, finalize and sign contracts and grants.

CHAPTER ONE

GENERAL CONTEXT

"A healthy and well-educated population is the driving force behind the development of a nation. Health is both the beginning and the end result of any country's development. That is why improving the health of the population is one of the basic pillars of the Sustainable Human Development Policy that the Republic of Madagascar has decided to implement."

JEAN LOUIS ROBINSON, MINISTER OF HEALTH AND FAMILY PLANNING

POVERTY AND HEALTH STATUS IN MADAGASCAR

Data from the World Health Organization (WHO) in 2001 shows that Madagascar was a distant 159 out of 191 countries ranked by health indicators. Clearly, Madagascar faces serious health problems affecting the social welfare of the population, the national economy and the environment. The Government of Madagascar (GOM) recognized that improving health, nutrition and food security is essential to the engine that drives economic development. In 2003, the Government of Madagascar developed a national strategy, known as the Poverty Reduction Strategy Paper (PRSP)[1], with the objective of reducing the poverty rate by half over the next 10 years. In its Strategic Theme No. 3, the PRSP regards health conditions to be factors that increase workers' short-term productivity and, over the long term, considers that improving health services for woman and children will impact their life expectancy and children's physical and mental development. Health objectives in the PRSP include promoting maternal and infant health, implementing essential nutrition activities, reducing infectious and non-infectious diseases, improving food security, and reducing vulnerability to natural disasters.

According to the most recent Demographic Health Study (DHS-2003), infant mortality is 58 per 1,000, the total fertility rate is 5.7 and contraceptive prevalence is 27 percent. Over 50 percent of children under age five suffer from malnutrition and over 80 percent of the population has no access to drinking water. Other studies show that despite the relatively low HIV/AIDS prevalence (one to three percent), Madagascar's rate of STI is among the highest in the world, with 21 percent of pregnant women suffering from syphilis (Struminger, 2000) and 76 percent of sex workers having at least one STI (Behets, Frida et al. 2003). In this context of high STI prevalence, HIV/AIDS could spread quickly and disastrously. Therefore, effective and immediate action is urgently needed.

Despite growing investments in health by the Government of Madagascar from five percent in 1998 to 10 percent in 2000, the quality and availability of priority health products and services remain problematic. To improve this situation, the emergence of the private sector in health must be supported; the public sector infrastructure, information and logistics systems must be strengthened; and pre-service and in-service training must be brought up to standards. Furthermore, to ensure the permanence of health products and services, efficient mechanisms for financing and cost recovery must be put in place and the security of essential medications and contraceptives must be ensured through reinforcing and recapitalization of SALAMA, Madagascar's parastatal medical procurement agency.

[1] *Document de Stratégie pour la Réduction de la Pauvreté* (DSRP)

MADAGASCAR'S ADMINISTRATIVE STRUCTURE

Madagascar's administrative structure:

6 provinces, 4 targeted by USAID

22 regions, 16 targeted by USAID

1,548 communes, 1,185 targeted by USAID

Madagascar Ministry of Health and Family Planning's structure:

9 Central Departments and 36 Units

22 Regional Health Divisions (RHD)

111 District Health Services (DHS)

2,430 Basic Health Centers (BHC), 1,813 located in USAID's intervention provinces

USAID'S ASSISTANCE FOR SUSTAINABLE AND INTEGRATED ECONOMIC DEVELOPMENT

The overall objective of USAID in Madagascar is to promote "Sustainable and Integrated Economic Development" and contribute to the PRSP goal of poverty reduction.

USAID's strategic objectives are aimed at improving good governance, increasing the use and improving the quality of selected health products and services, improving the protection of biologically diverse forest ecosystems, and expanding and strengthening critical private markets.

USAID'S ASSISTANCE FOR HEALTH IMPROVEMENT

USAID's experience shows a strong cause-effect relationship between these strategic objectives and these vital interrelated sectors. USAID would like to contribute to reinforcing innovative approaches that integrate the sectors of food security, health, population and environment, HIV/AIDS prevention, good governance, information technology and communications, vulnerability to disasters and conflicts, gender equity and alliances between the public and private sectors.

USAID has demonstrated long-term commitment to improving health status in Madagascar. The APPROPOP project (1993–1998) was designed to increase the number of Malagasy practicing modern family planning. The Jereo Salama Isika project (1999–2003) sought to decentralize health care, improve the quality of services, and encourage local communities to be responsible for their own health. The Santénet project (2004–2008) is the third phase of USAID's assistance to the Government of Madagascar to improve the health and the well-being of the Malagasy population.

CHAPTER TWO

ABOUT SANTENET

GENERAL AND SPECIFIC OBJECTIVES

Under the implementation of the Government of Madagascar's General Health Policy, the Ministry of Health and Family Planning (MOH/FP) focuses its efforts on the main areas identified in the National Health Policy, which include decentralizing the national health system; improving efficiency of health sector financing; expanding the private sector; promoting community mobilization for health development, protection and promotion; and disease control.

Building on USAID's previous health projects' achievements, Santénet seeks to assist the MOH/FP to achieve the following intermediate results:

Increasing the Demand for Health Products and Services (Intermediate Result 1). IR 1 strives to *increase the demand* for health products and services so as to promote family planning, improve child health, combat malaria, and prevent STIs, including HIV/AIDS. To this purpose, IR 1's activities are intended to reinforce community mobilization and IEC/BCC (IR 1.1), involve the private sector in health promotion (IR 1.2), and target priority biodiversity conservation areas (IR 1.3).

Increasing the Availability of Health Products and Services (Intermediate Result 2). The activities of IR 2 strive to *increase access* to these services and products. Santénet provides technical support to MOH/FP and to its partners to ensure better availability and access to the necessary services and health products to encourage family planning, to improve child health, to combat malaria, and to prevent STIs, including HIV/AIDS. Specifically, the activities of IR 2 will improve the logistics systems in the public sector (IR 2.1), support the development of a private sector distribution network for socially marketed products (IR 2.2), increase access to priority services for remote populations (IR 2.3), improve the nutritional value of agricultural products (IR 2.4), and improve water management for agriculture and households (IR 2.5).

Improving the Quality of Services Provided (Intermediate Result 3). IR 3 is working to *improve the quality* of health services. Better services will help encourage family planning, improve child health, control malaria, and prevent HIV/AIDS. In order to improve the quality of such services, IR-3 activities are designed to strengthen and improve the Policies, Standards and Protocols (PSPs) for health services in the public and private sectors (IR 3.1), improve service providers' ability to provide high-quality health services (IR 3.2), and introduce operational models for quality assurance (IR 3.3).

Strengthening Institutional Capacities (Intermediate Result 4). Overall, IR 4 activities will reinforce the health system and support civil society and NGOs to implement health activities in order to promote family planning, improve children's health, fight malaria and prevent STIs, including HIV/AIDS. *Institutional capacity building* comes through the improved collection and use of data for decision making (IR 4.1), better access to health information (IR 4.2), the ability of NGOs to implement health programs (IR 4.3) and the capacity of civil society to be an advocate for public health (IR 4.4).

SANTÉNET'S TECHNICAL ASSISTANCE

1. Technical assistance in design, i.e. activities' conceptual development or design
2. Technical assistance in training, i.e. development of training curricula and/or training of trainers
3. Technical assistance for evaluation, i.e. development of evaluation criteria, and active participation in result analysis
4. Logistics and financial assistance, i.e. participation in logistics organization and financial support to participant attendance.

SANTÉNET'S STRATEGIC APPROACH: PARTNERSHIP

In order for Santénet to achieve its objectives and contribute to improving the well-being of the Malagasy people, the project will collaborate closely with partners in the public and private sectors to achieve common health objectives by implementing proven best practices and innovative approaches.

Partnership is the foundation of all activities planned in the framework of the Santénet project. This partnership exists when organizations with common objectives and complementary areas of expertise commit their resources and work together to produce results that would be difficult to achieve alone. The Santénet partnership vision suggests that *synergy* between partners is created based on *common objectives* and built through the partners' contribution of *added values* with the goal of achieving better results together.

Partnering with the public sector. Santénet works directly with and for Madagascar's Ministry of Health and Family Planning, the National AIDS Control Committee, as well as with other concerned ministries and administrative entities.

Partnering with the private sector. Santénet also collaborates closely with international and local NGOs, private companies, the media, and training institutions that play key roles in promoting health in Madagascar. In addition, through its Santénet Fund, the project enables local organizations to implement activities and contribute not only to achieving the health objectives of the program, but also to reinforcing local institutional capacities and thus ensuring the long-term permanence of the program.

Partnering to implement best practices and innovative approaches. To maximize the impact of project resources and build on past efforts, Santénet always strives to follow a highly consultative process for creating consensus among all relevant entities regarding successful models and approaches that should be targeted for replication and scale-up. Instead of developing new models, Santénet builds on lessons learned from previous projects in Madagascar and worldwide to improve on existing models and mobilize different partners for their implementation at a larger scale.

Partnering to achieve common objectives. Santénet adds value and fosters synergies with partners around common objectives to improve the well-being of the Malagasy people. While Santénet's main focus is on health, the approach is a multisectoral one that entails collaboration with other important development projects and programs, funded by USAID and other agencies, such as environment, governance, and economic growth.

SANTÉNET'S STRATEGIC APPROACH: NATIONAL AND LOCAL LEVEL INTERVENTIONS

Santénet operates at both the national and local levels to improve indicators. Activities will be implemented at the national level to influence national policies, norms and procedures that will increase the demand for, increase access to and improve quality of selected health services and products, while building institutional capacity at a ministerial, or central, level. Santénet will also design activities that trickle down to the local level, i.e. the Basic Health Center (BHC) and the community, and that ensure that the end beneficiary, the local population in USAID's four intervention provinces – Antananarivo, Toamasina, Toliara and Fianarantsoa – benefits from better information about, better access to, and improved quality of health services and products.

CHAPTER THREE: INTERMEDIATE RESULT 1 (IR 1)

INCREASING DEMAND FOR SELECTED HEALTH SERVICES AND PRODUCTS

This section describes the activities accomplished under IR1 in Santénet's first year of implementation. This is followed by a description of the impact of these activities. Selected regional activities are highlighted within the section, which ends with a graphic timeline of activities conducted from June 2004 to September 2005.

INTRODUCTION TO THE INTERMEDIATE RESULT

IR 1 strives to *increase the demand* for health products and services so as to promote family planning (FP), improve child health, combat malaria, and prevent STIs, including HIV/AIDS. To this purpose, IR 1's activities are intended to reinforce community mobilization and information, education, communication and behavior change communication (IEC/BCC) (IR 1.1), involve the private sector in health promotion (IR 1.2), and target priority biodiversity conservation areas (IR 1.3).

Reinforce community mobilization and IEC/BCC (IR 1.1). An increase in demand for health services and products requires knowledge of healthy behaviors, positive attitudes toward modern health care, and a desire to seek and use health services and products. Increasing community involvement in efforts to improve health at the local level has proven effective in changing behavior. Furthermore, IEC/BCC materials and campaigns are an important element for getting health messages to communities and complement community mobilization efforts.

Involve the private sector in health promotion (IR 1.2). The private sector has an important role to play in the promotion of health. Private businesses should contribute to prevention efforts not only within their own company, but also within their community, since they will be the first to benefit from strong and healthy employees with healthy families.

Target priority biodiversity conservation areas (IR 1.3). Health, Population, and Environment (HPE) activities are a priority for USAID Madagascar and past efforts have demonstrated success in improving health indicators among remote populations while reducing pressures which can lead to environmental degradation. Areas located in what is known as the

"biodiversity corridor" are considered priority biodiversity conservation areas and should be targeted for HPE activities.

2004-2005 ACHIEVEMENTS

"There are many health communication actors who have developed and used their own messages to promote better health among the Malagasy population. In spite of these much appreciated efforts, it is evident that this diversity of messages was not the most effective approach. This Health Communication and Mobilization Committee will serve as a platform for multiple, but coordinated, actions and efforts toward one common objective of changing the population's behavior so that the well-being of the population becomes a reality."

ERLINE RASIKINDRAHONA, DIRECTOR OF HEALTH PROMOTION, MIINISTRY OF HEALTH AND FAMIILY PLANNING

IMPROVING COMMUNITY MOBILIZATION AND IEC/BCC FOR SELECTED HEALTH PRODUCTS AND SERVICES (IR 1.1)

Set up the Health Communication and Mobilization Committee and its three Sub-committees. The National Health Policy is designed to improve public health in Madagascar. Its general objectives include a strategic focus of improving health through health education and community mobilization activities, which constitute essential and cost-effective components of disease prevention. All health education and community mobilization activities are implemented under the leadership of the Ministry of Health and Family Planning (MOH/FP), in collaboration with all health communication partners. MOH/FP's IEC and Social Mobilization Unit (IECSMU) strengthens collaboration amongst all the actors working in health education and community mobilization activities. The IECSMU established the Health Communication and Mobilization Committee (HCMC) as one way to improve collaboration.

Santénet contributed to drafting the HCMC terms of reference, based on terms of reference (TOR) from the previous IEC Task Force[2]. Santénet provided subsequent technical and financial support for the official launch of the revamped Committee. Santénet continued to assist the IECSMU in defining the Committee's standard operating procedures and setting up three technical sub-committees: Family Health, Infectious Diseases, and Non-infectious Diseases. Santénet was appointed secretariat of the Committee. The reformed HCMC is composed of approximately 80 members from the public and private sectors. The Committee is now fully operational, having held several technical meetings to validate IEC/BCC materials developed by the members, including Santénet's own *Kôminina Mendrika* materials.

Contribute to the development of the National Family Planning Communication Strategy. Madagascar is, along with Mali, one of the two African countries that have begun to reinvigorate its national family planning program, beginning by revamping its national strategy. In order to include FP as a health priority to achieve economic, social and health development, the Government of Madagascar and all its health partners developed a new FP strategy aimed at expanding ongoing activities, initiating new activities and bridging cultural or structural gaps. The new Family Planning National Strategy includes three main components:

1. Increasing the demand for services
2. Increasing the availability of services
3. Creating a favorable environment for FP

The first component defined a new BCC strategy, developing communication messages and materials which take into account the needs and concerns of various target populations, as well as the local context. The Family Health Division (FHD) and the IECSMU organized preliminary meetings to design the new FP communication strategy, in which Santénet participated as a technical partner. The three partners worked together to outline steps for the FP communication strategy. With technical, logistic and financial support from Santénet, MOH/FP organized a technical workshop that used the outline as a tool to develop the FP communication strategy. Participants identified preliminary steps to create the strategy, and UNFPA funded the first step — a literature review, which was carried out by national consultant, J.D.M. Rakotomanga. The MOH/FP presented the results with technical support from UNFPA and Santénet. The report[3] will be used as a reference document, and represents an important first step in the process of developing a national FP communication strategy.

[2] Until 2002, the IEC Task Force was a consultative platform designed to foster efficient exchanges between the different partners involved in IEC/BCC in the health sector. During Madagascar's political crisis of 2002, the IEC Task Force's activities were suspended and have since been on hold.

[3] "Situational analysis of socio-cultural studies on RH/FP in Madagascar"

SANTENET 2005 (SETA)

In implementing the *Kôminina Mendrika* approach, support technicians from the implementing NGO periodically visit the communes to monitor progress toward the set health objectives.

The MOH/FP's goal is to have the FP communication strategy developed by March 2006. To fill the gap in terms of FP communication activities, Santénet and the Health Communication Partnership recommended that mini-campaigns be implemented by broadcasting existing TV and radio spots. FHD, IECSMU and FP partners have agreed, and all the existing spots will be reviewed to select the most effective and relevant ones.

Develop a community mobilization approach (Kôminina Mendrika) and launch it at a large scale. The implementation of a community-based approach is one of the strategies Santénet is employing to increase demand for health products and services.

Santénet developed the "*Kominina Mendrika*" (KM), or "Champion Commune" approach by building upon the experience of past projects while introducing three innovative elements that will broaden the scale, scope and impact of KM:

1. *Scale*: implementation has moved from the community level to the administrative commune level, and a greater number of communes are targeted (300 communes over 3 years),
2. *Multisectoral development*: KM has been expanded to serve as a social mobilization platform for other development sectors (environment, governance, economic growth) to achieve the integrated development strategy promoted by USAID, and
3. *Implementation by local entities*: international and national NGOs implement the approach, rather than the project itself, thereby building local capacity and ensuring sustainability.

At the beginning of the project, Santénet drafted a new technical approach, based on the innovations described above and then introduced the new approach and solicited feedback from local stakeholders. After finalizing the technical approach, Santénet solicited proposals through a competitive process. After several weeks of discussions and negotiations, and subcontracts were signed with MCDI, CARE, ADRA, and CRS; grants were signed with SAF-FJKM, SALFA, ASOS, Voahary Salama, TANTSIKA, MATEZA, MICET and AINGA. Chapter IX provides more information about the modalities of grant/subcontract activities. The NGOs began implementing the approach in September 2005 with the KM's official introduction at the commune level. To date, the KM approach is being implemented in 80 communes in the provinces of Antananarivo, Toamasina, Fianarantsoa and Toliara.

In addition, Santénet developed the following tools for *Kôminina Mendrika*: marketing tools to promote the

FOCUSED LOCAL LEVEL ACTIVITITES

Although Santénet will strive to touch as many communities in the four intervention provinces as possible, project resources for local-level activities will be directed as much as possible toward the *Kôminina Mendrika* communes.

approach, outreach tools to ensure effective inter-personal communication, and mass media tools to reinforce community outreach messages. The development of KM support tools followed HCMC guidelines and were approved by the Committee.

In collaboration with the MOH/FP, Santénet undertook baseline surveys in the selected communes to collect data that will help set realistic, significant objectives in each KM commune.

Field visits were also undertaken during which Santénet provided guidance to NGO leaders to help them appoint support technicians (ST) who can effectively perform the duties to ensure the approach's success. Santénet then organized a training of trainers in IEC/BCC, community mobilization, and communication techniques for STs. Subsequently, the trainers will provide training to *Kôminina Mendrika* Committees and community outreach workers in their respective communes. In all, 290 STs were identified and trained.

Province	Number of KM communes
Antananarivo	4
Toamasina	34
Fianarantsoa	23
Toliara	19

Develop an urban mobilization approach (Tanàna Mendrika) and initiate a pilot project. The *Kôminina Mendrika* approach was designed for rural communes. However with over 26 percent of Malagasies living in urban areas[4], there is a need to address the needs of urban populations. Santénet has responded by piloting the "*Tanàna Mendrika*" (Champion Town) approach in the urban commune of Fort Dauphin to address health issues particular to an urban environment. Working with CARE, Santénet introduced the TM concept to local leaders. Responding enthusiastically to the idea, the Regional Director, town council, the tourism sector and the regional health director are identifying sanitation strategies to not only improve the health status of the population but also increase tourism.

Provide media support to mass campaigns. Among the strategies implemented to improve health, social mobilization and IEC/CCC play an important role by encouraging households to adopt healthy behaviors. Evidence has demonstrated that a multi-channel approach to IEC/BCC is the most effective method to encourage behavior change. Therefore, mass media campaigns are a key element in effective IEC/CCC activities, and are particularly strategic in a country like Madagascar where 85 percent of the population lives in rural areas that are often difficult to reach through more interpersonal methods.

During its first year of operations, Santénet contributed to three major health campaigns: the HIAKA 2004 measles immunization campaign, World Health Day, and the Vitamin A mass distribution campaign. For all these campaigns, Santénet provided technical and financial assistance to the IECSMU to develop and broadcast TV and radio messages.

Train the public sector in IEC/BCC. Each central department of MOH/FP has an IEC/BCC specialist responsible for developing efficient health communication programs and ensuring that all IEC/BCC materials developed by the ministry or its partners are technically correct before they are submitted to IECSMU for final validation. MOH/FP recognized, however, that these specialists needed to strengthen their role within their department. Santénet, which had provided IEC/BCC training for the KM approach, was solicited by MOH/FP to organize a series of IEC/BCC training sessions for MOH/FP's IEC/BCC specialists, to be held in October 2005. Santénet helped IECSMU in developing the training curriculum, and has been asked to facilitate some of the training sessions.

[4] UNDP Human Development Report 2005

INCREASING PRIVATE SECTOR INVOLVEMENT IN PROMOTING HEALTH SERVICES AND PRODUCTS (IR 1.2)

Train the private sector in IEC/BCC.

Among the strategies to increase demand, Santénet considered the increased involvement of the private sector. During this year, one of Santénet's key private sector partners is the pool of KM partner NGOs. In order for the 11 partners to effectively implement the KM approach, the capacity of their field personnel to lead IEC/BCC activities needed to be strengthened. Santénet developed the IEC/BCC Guide to give guidance to community outreach workers and their support technicians (ST) on how to transfer messages effectively to the different target groups in the KM communes. In August 2005, Santénet conducted a series of three-day training of trainers in IEC/BCC in all four provinces for the STs. The BHC chiefs of staff were also invited to participate. As mentioned in the KM activity description above, these 290 trained STs will in turn train their community outreach workers and the commune's *Kôminina Mendrika* Committee in IEC/BCC.

INCREASING DEMAND FOR FP AND HEALTH SERVICES AND PRODUCTS IN PRIORITY CONSERVATION AREAS (IR 1.3)

Integrate health and environment through the Kôminina Mendrika approach.

Kôminina Mendrika mobilizes all stakeholders at the commune for important and achievable actions which change behavior and promote development, regardless of sector. Santénet provided technical and financial support to promote collaboration between health and environment sectors to harmonize approaches and to integrate health and environment activities in select communes. Eleven communes were identified for year one, five in the Toamasina Province, and six in Fianarantsoa, and all located in the biodiversity corridor. Santénet has participated in Ecoregional Alliance meetings initiated by Ecoregional Initiative (ERI), while ERI technicians took part in KM meetings, start-up workshops, and IEC/CCC TOT organized by Santénet. The partner NGOs implementing the health component in those communes will also be implementing the environment component, with technical assistance from ERI. In September 2005, the KM partner NGOs introduced the integrated

SANTENET 2005 (SETA)

A community outreach worker is educating local villagers on simple but important actions to take to improve their health and that of their families.

approach in the 5 communes of Toamasina. The introduction in the Fianarantsoa will take place in October 2005. Kristen Patterson, the University of Michigan Population-Environment Fellow, is based in the Santénet Fianarantsoa office and is working to ensure effective integration of health and environment in the Fianarantsoa region.

STI/HIV/AIDS

Adapt and roll out HIV/AIDS prevention activities for youth. Santénet, in collaboration with Health Communication Partnership (HCP), introduced "*Ankoay,*" an HIV/AIDS prevention approach that involves boys and girl scouts. This approach has been used successfully in Ethiopia and is being adapted to the Malagasy context. The *Ankoay* approach is based on peer education and seeks to promote youth leadership in activities at a community level. It encourages positive behavior changes towards HIV/AIDS prevention, first among the members of the scouting federation, and eventually among non-scout peers. Activities accomplished to date include training of scout leaders, producing *Ankoay* material by adapting Ethiopia IEC materials, and the organization of a mini-festival in February 2005 to officially launch the approach. Currently, 100 scout troops in nine regions of Madagascar have been trained in the *Ankoay* approach. The ES/NACC, the Ministry for Youth and Sports, the Ministry of Health and Family Planning have all approved *Ankoay*. The ES/NACC has increasingly adopted *Ankoay* as its methodology of choice for all youth-targeted interventions.

HIGHLIGHTS FROM SANTENET'S REGIONAL OFFICES

Kôminina Mendrika in Toliara. In the province of Toliara, Santénet launched the Kôminina Mendrika approach in 19 communes. To select communes, the Santénet Toliara regional office collected information from all the local actors and partners, and then visited the field with the partner NGOs — MCDI and ASOS. From the onset, the Toliara team also established a solid collaborative base between the partners NGOs and the Region Chief and all the regional and local health facilities to facilitate implementation. The team also field tested the Kôminina Mendrika materials, facilitating focus groups in Toliara, assisted in the the implementation of baseline surveys, and participated in the IEC/BCC training of trainers in Toliara.

Vitamin A campaign in Fianarantsoa. Santénet provided important financial and technical support to the Regional Health Director in the Fianarantsoa province for the official launch of Vitamin A campaign which took place from April 25-29, 2005 in the Sahambavy commune, presided over by the President of the Fianarantsoa Province and hosted by MAJEUR 7, a famous local band. In addition, MAJEUR 7 wrote a song especially for the campaign, related to Vitamin A and to deworming, which was broadcast on local radio before, during and after the campaign.

Integrating health and environment in Toamasina. Santénet is an active member of Toamasina Ecoregional Alliance and participates regularly in the Alliance's monthly meeting. The Toamasina Ecoregional Alliance is a consortium of different USAID partners working in the "biodiversity corridor" within the Toamasina province. Members strive to find ways to integrate activities from the different development sectors that ultimately enable to alleviate the pressure on the forest and its biodiversity. Among the 34 KM communes in the province, five communes were chosen by Santénet and Ecoregional Initiative (ERI) where the integrated health-environment KM approach will be implemented by ASOS and Mateza.

2004-2005 IMPACTS

Improved coordination between partners for a better mobilization and use of financial, material and human resources for IEC/BCC. The creation of the Health Communication and Mobilization Committee (HCMC) will reinforce health communication, so that awareness-raising and IEC/BCC remains a highly effective strategy for disease prevention. This committee enables dialogue between the various departments and partners of MOH/FP involved in health prevention and education. Through meetings, members were able to mutually agree to medium-term needs and priorities, which will ensure a better use of financial, material and human resources to achieve common goals. Current priorities include the development of a minimum package of IEC/BCC health materials, which should be available initially in all BHCs of the country (*Santénet Indicator 7,*) as well as the development of the national FP communication strategy, to support the new National Family Planning Strategy and increase the contraceptive prevalence rate (*Santénet Indicator 1)*. As project indicators are included as priorities for the government and other health actors, it increases the likelihood of success and sustainability for these activities.

Reinforcement of MOH/FP's Information Education Communication and Social Mobilization Unit (IECSMU) and of the process of development of IEC/BCC materials. The official creation of the HCMC has solidified the IECSMU's role as a leader in IEC/BCC. This allows the IECSMU to become automatically involved in IEC/BCC material development process, which was not always the case in the past. Furthermore, in order to standardize IEC/BCC tool development, a standard process for the development of IEC/CCC tools has been proposed by the IECSMU which requires the systematic use of focus groups to pre-test all materials, as well as the endorsement of the HCMC partners. This will ensure that messages conveyed by partners will conform with the GOM National Health Policy, and will better ensure that messages are effectively formulated. Santénet has been the first to comply with these new procedures during the development of the KM materials.

Joint efforts by all FP partners for awareness-raising activities. Santénet was one of first FP partners, with UNFPA, to support the Family Health Division (FHD) and the IECSMU, in order to mobilize partners, members and non-members of the Family Health Sub-committee, and to define in a participatory manner the different steps of development of the national FP communication strategy. The participatory process has resulted in greater stakeholder involvement and improved collaboration on key decisions. The partners will jointly develop mini FP communication campaigns while waiting for the finalized communication strategy (scheduled for March 2006). These transitional mini-campaigns will maintain, if not reinforce, FP's visibility since the National FP Conference held in December 2004, and contribute to increasing demand for FP services (*Santénet Indicator 1*).

Reinforced Public-Private Partnerships for the development of communes. The *Kôminina Mendrika* (KM) approach conforms to the Government of Madagascar's development strategy, which decentralizes development efforts to regional and communal levels and ensures more responsive, more accountable development actions.

Santénet engaged 11 national and international NGOs to implement KM in 80 communes for the first year of implementation (*Santénet Indicator 6*). Through KM, Santénet gained the support of public health officials and of administrative authorities. This strategic partnership will not only engage regional and local leaders in improving health in their regions and communes more effectively, but will also strengthen the collaboration between local government and NGOs.

Through the KM partners, Santénet will directly reach 1,164,879 inhabitants in the first year of implementation, raising awareness on FP, malaria, child health and HIV/AIDS. KM activities will contribute to increased contraceptive prevalence rates (*Santénet Indicator 1*), DTC3 coverage rate (*Santénet Indicator 3*), Vitamin A supplementation (*Santénet Indicator 3*), exclusive breastfeeding rates (*Santénet Indicator 5*), and condom use (*Santénet Indicator 4*).

Expanded Kôminina Mendrika implementation. The promise of the KM approach is already palpable. Despite the short period of implementation, several organizations have already expressed their interest in expanding the KM approach to other communes. CARE is implementing KM in other communes in Toamasina province, utilizing other monies to finance the KM activities. Other organizations, such as the Malagasy Red Cross and Ecodism, have contacted Santénet to explore collaboration for KM's second year. This keen interest expressed by so many diverse partners is extremely promising and shows the approach's potential for success and sustainability.

Kôminina Mendrika integrated across development sectors. *Kôminina Mendrika* aims to integrate the key development sectors: environmental protection, health, economic development and good governance. These sectors are interdependent and must be integrated in order to ensure rapid and sustainable development. As the initiator of the *Kôminina Mendrika* approach, Santénet continues to promote the approach across development sectors, with success. Five of the 81 communes are currently integrating health and environment with another six planned for the near future (*Santénet Indicator 5*).

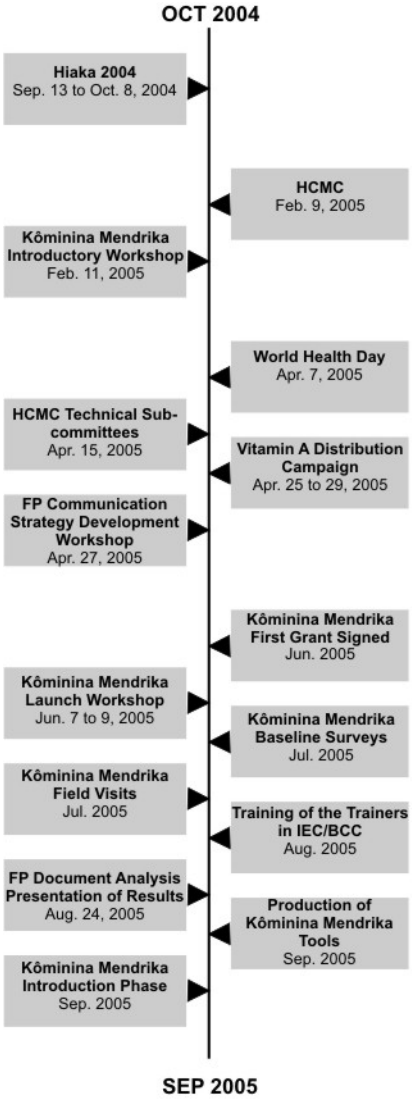
MISONGA/USAID and UNICEF have begun to integrate the good governance component by educating women receiving prenatal care about birth registration.

Youth mobilized in the fight against HIV/AIDS. In 2005, 100 scout troops were trained and are implementing *Ankoay* activities, directly engaging 2,500 scouts. The *Ankoay* approach is now recognized by ES/NACC as a best practice for behavioral change targeting youth and is exploring ways to scale up the approach within the scout movement and expanding the approach to non-scouts through sports, music, and art.

SANTENET 2005 (SETA)

A troop of teenage boy scouts is being trained on the *Ankoay* approach and on various games and activities to raise awareness within the troop on HIV/AIDS prevention.

IR1 TIMELINE



SUCCESS STORY

Discovering the Real Meaning of Partnership

USAID fosters public-private partnership to improve health at the local level in Madagascar

John Tomboarivo is the head doctor in the basic health center of the Beheloka commune. To help his commune achieve the health objectives required to become a Champion Commune, he has taken the initiative to vaccinate children and give free consultations to pregnant women who live too far from his health center.

Finding solutions to development challenges at the local level requires the engagement of all local actors. John Tomboarivo is the head doctor in the basic health center of the Beheloka commune. He and the other members of the Champion Commune Committee — the mayor, the traditional leaders, the school director, representatives of ASOS Sud, a local NGO — are working hand in hand to find creative ways not only to motivate the commune, but also to contribute to the achievement of the health objectives they have set out.

The Champion Commune approach seeks to involve all local leaders, groups and individuals in a commune to achieve common objectives that will lead to positive social, economic and cultural development, including improvement in health. These actors achieve predefined objectives through actions that are vital but "doable" — with tangible and measurable results which foster sustainable behavioral change. The success of the commune requires a close partnership between the public and the private sector and the participation of all individuals — the mayor, the head doctor, parents — and groups, including schools, special interest groups, the church. A commune becomes a Champion Commune when it demonstrates that it has achieved these predefined objectives.

In the area of health, these objectives include increasing the number of contraceptive users, improving pregnant women's health by increasing the number of women being vaccinated against tetanus and receiving regular iron intake, increasing the number of children vaccinated and receiving vitamin A supplements, and preventing malaria by increasing the number of pregnant women and children sleeping under insecticide-treated bed nets.

In 2005, USAID initiated the approach in 81 communes with the help of 11 local and international NGOs. Among these is the commune of Beheloka, in the province of Toliara, in the southwestern part of Madagascar. ASOS Sud is the implementing partner.

Through the Champion Commune approach, USAID Madagascar seeks to contribute to the Government of Madagascar's objective of implementing a rapid and sustainable development policy that directly benefits the local population. USAID aims to initiate the Champion Commune approach in 300 communes of Madagascar by 2008.

CHAPTER FOUR: INTERMEDIATE RESULT 2 (IR 2)

INCREASING AVAILABILITY OF SELECTED HEALTH PRODUCTS AND SERVICES

Activities accomplished under IR 2 are described below, followed by an analysis of the impact of these activities over the first year of the project. Activities of interest from the regions are scattered in the chapter, along with a timeline of activities.

INTRODUCTION TO THE INTERMEDIATE RESULT

Whereas IR 1's focus is to increase demand for services and select health products, the activities of IR 2 strive to *increase access* to these services and products. Santénet provides technical support to the MOH/FP and its partners to ensure better availability and access to services and health products that encourage family planning, improve child health, combat malaria, and prevent STIs, including HIV/AIDS. Specifically, the activities of IR 2 will improve the logistics systems for the public sector (IR 2.1), support the development of a private sector distribution network for socially marketed products (IR 2.2), increase access to priority services for remote populations (IR 2.3), improve the nutritional value of agricultural products (IR 2.4), and improve water management for agriculture and households (IR 2.5).

Improve the logistics systems for the public sector (IR 2.1). SALAMA, the central drug purchasing agency, procures generic essential drugs (GED) and delivers them to the district level who in turn assumes the responsibility of getting drugs to the basic health centers (BHC). However, weaknesses in commodity management and distribution systems represent serious impediments to ensure consistent availability of health products. All levels lack reliable forecasting and stock management systems resulting in repeated stock-outs. The cold chain, which ensures the delivery of vaccines and other drugs that require certain storage conditions, also periodically experiences problems due to lack of spare parts and fuel shortages for equipment. An inadequate cost recovery system endangers the sustainability of the public health systems' ability to deliver quality health services and products. It is thus urgent to address deficiencies in the commodity management and distribution system.

Support the development of a private sector distribution network for socially marketed products (IR 2.2). The private

sector in Madagascar has played an important role in ensuring the availability of health products, especially socially marketing products like condoms, bed nets, and safe water products, and seeing that product availability corresponds to increased demand. However, the role of the private sector should be expanded in order to relieve the burden on the public sector and provide greater access and choice to the Malagasy people.

Increase access to priority services for remote populations (IR 2.3). Availability of health services and products is also a concern, particularly for the most underserved populations in remote, disaster prone, and priority conservation areas. Over 80 percent of the Malagasy population lives in rural areas and 65 percent are estimated to live within a 5-kilometer radius from the nearest health service. Despite this level of coverage, numerous barriers to health care remain: geographic access is impeded due to poor road conditions, especially during the rainy seasons, economic barriers as curative care services require payment which is outside the reach of many Malagasies, service provision is often not conveniently offered to the population who spend much of their days working in the field. For example, overwhelming numbers of clients have resulted in long wait times for receiving services.

Improve the nutritional value of agricultural products (IR 2.4). Malnutrition is a serious health issue in Madagascar: over 50 percent of children under age 5 suffer from malnutrition, resulting in stunted growth rates and increased vulnerability to disease. Families, especially in rural areas, have limited income and their diets often lack nutritional balance. In order to reduce malnutrition, knowledge and attitudes regarding nutrition must be improved. This implies that high nutritional value foods must also be made available to households and local communities.

Improve water management for agriculture and households (IR 2.5). Contaminated water is an important cause of water-borne diseases, including diarrhea, a major cause of child mortality. In Madagascar, access to safe water (through household connection or public standpipe) is estimated at about 65 percent in urban areas, and only between 10 to 20 percent in rural areas. Although several donors and NGOs are working to provide long-term solutions to safe water access, water security is a critical and immediate household, livelihood and health issue. PSI Madagascar is currently marketing a safe water system locally known as "Sûr'Eau" which addresses the issues of contaminated source water and unsafe water storage. Efforts should be undertaken to ensure better access to this socially marketed product.

2004-2005 ACHIEVEMENTS

IMPROVING THE LOGISTICS SYSTEM FOR THE PUBLIC SECTOR (IR 2.1)

Provide technical assistance to SALAMA. The public health system's generic essential drugs (GED) distribution chain includes the Central Purchasing Agent SALAMA, PHAGDIS (wholesale district pharmacies) and PHAGECOM (community-managed pharmacies) at the end of the chain. In early 2004, the Government of Madagascar, SALAMA and the donors who finance contraceptives in Madagascar, the World Bank, UNFPA and USAID, decided to integrate the contraceptive products distribution system with the GED distribution system in order to reinforce contraceptive security.

Santénet provided support for the implementation of the strategy for contraceptive security through technical assistance in the use of the software PIPELINE, used for forecasting and defining needs. Santénet also assisted the group of FP partners[5] in the development of the Procurement Plan for contraceptive products for 2005.

Together with MOH/FP central staff, Santénet facilitated the introduction of the new training curriculum on contraceptive product management. This training targeted health district SR/PF managers in order to reinforce their technical capacity in the contraceptive products procurement, and to explain how to be compliant with new norms, standards and procedures in the integrated distribution system.

[5]FP Partners: SALAMA and financial partners

"I agree completely with His Excellency the President of the Republic of Madagascar on the repositioning of Family Planning in order for Madagascar to be among those countries that have achieved the Millennium Development Goals in 2015."

JACQUES SYLLA, PRIME MINISTER AND CHIEF OF GOVERNMENT

Support the initiative to update the National FP Strategy. Madagascar is, along with Mali, one of the two African countries that have decided to reposition family planning as a government priority, recognizing family planning as a strategy that will contribute to larger development goals. Results from the DHS 2003 gave a more accurate depiction of the prevailing situation, demonstrating that the national FP strategy needed review to better respond to the current situation.

Santénet was a major technical and financial partner of the MOH/FP in the participatory update of the national FP strategy. Santénet provided support to the MOH/FP for the organization of mini-workshops on specific topics for technical assessment: sources of procurement and services; range of products and services; demand generation and advocacy; and institutional, legal and regulatory framework and funding. The MOH/FP then organized a national conference to validate the assessment results and to determine necessary adjustments. Santénet provided continued technical assistance to MOH/FP for the development of the National FP Strategy. This series of activities gathered together over 500 people from public and private sector involved in FP programs in Madagascar. This process resulted in the adoption of a new FP strategy and secured the strong support of the President. The support of the President prompted the creation of a Family Planning Program Executive Secretariat, which will be responsible for ensuring the leadership, coordination, and effective implementation of the National FP Strategy.

In addition, Santénet also provided technical and financial support to the MOH/FP for advocacy and awareness-raising workshops on the maternal and child health and family planning program, targeting political authorities, public administrators, religious leaders, donors, and journalists in nine major cities throughout the island. The goal of these workshops was to explain the importance of the maternal and child health and family planning program in poverty reduction, to secure a consensus among stakeholders on implementation strategies. These advocacy and awareness-raising workshops brought together over 500 participants, including authorities from various sectors. As a result, district health divisions decided to use FP data from the DHS 2003 when developing their annual work plans.

Support the health districts and NGOs in the areas selected for organizing advanced strategy operations (like "children's health week") including Vitamin A supplementation, promotion of Insecticide-treated Netting (ITN) and other interventions. As an active member of the Roll Back Malaria (RBM) technical network, Santénet helped to develop the new national malaria policy. This policy defines the new principles for prevention (the introduction of the new treatment protocol, evaluating the national malaria control strategy against the objectives of the Abuja Declaration), treatment, and monitoring and evaluation for malaria control in Madagascar. The RBM partnership is established mainly to enable group decisions on key malaria program issues and provide technical and logistics support to the MOH/FP's Malaria Control Unit so it can effectively act as RBM coordinator. An example of a key issue discussed within the RBM group is a more rational distribution of insecticide-treated nets (ITN) that prioritizes pregnant women and children under age 5 in malaria-endemic zones.

Proposal to Fifth Round of the GFATM: Santénet provided technical expertise to all sectors, in particular to the Malagasy NGOs, in drafting country proposals for the Global Fund for AIDS, Malaria and Tuberculosis (GFATM). Santénet actively participated in all working group sessions to prepare the financial proposal. This technical assistance is added to the efforts to mobilize the resources necessary for the malaria campaign.

Nutrition: During the year 2004-2005, through the participation of its technicians in different technical meetings for drafting, reviewing documents and co-funding workshops with other partners, Santénet actively supported the development of the PNN and the PNAN. These two documents will be reference documents for all national nutrition activities, under the coordination of the ONN.

Provide technical assistance to the National Drug Agency (NDA). The National Drug Agency, the MOH/FP agency responsible for quality assurance of drugs, worked with Santénet to identify requisite

technical skills for quality assurance, as well as analyze the infrastructure, equipment and supply needs to conduct quality assurance testing. While providing the needed materials support is outside the mission of Santénet, the NDA does receive technical and financial support from USPharmacopea to upgrade its testing facilities. The analysis allowed the NDA and its donor to target its support most effectively.

Reinforce all levels of the public chain of distribution (SSD, PHAGDIS, PHAGCOM). During the first quarter of 2005, Santénet assisted the MOH/FP and SALAMA to design a tool to evaluate SSD performance in integrating contraceptive products into the essential drugs distribution system. The quarterly evaluation is based on the delivery schedule from SALAMA to the health districts, and the results identify specific actions for each SSD to improve their performance.

Santénet also worked with the MOH/FP to conduct six training sessions on FP Management in September 2005. Since the integration of contraceptives into the GED distribution network is relatively recent, it was important that PHAGDIS providers from all districts participate in these workshops, together with SSD FP managers, to make sure all interested persons understood the tools and procedures the same way.

To build the capacity of the members of the Basic Health Center Management Committee (BHC/MC), Santénet, with MOH/FP's Community Participation Unit, determined the need for training for the BHC MC (members include PHAGECOM management team: President, Treasurer, service providers and BHC Heads even in Districts where this was not part of their planned activities). The training targeted four members from targeted BHC MC. Trainers from EMAD (District Management Team) used the approved curriculum to train BHC/MC members in management techniques and tools to improve management of the GED cost recovery system (French acronym FANOME). BHC/MC members in Toamasina and Fianarantsoa provinces received this training, as well as personnel in four health districts; in total, 440 people were trained in Santénet's first year of operation.

Participate in consolidating health system financing in Madagascar. One objective of the Government of Madagascar is to provide basic medical coverage for 80 percent of Madagascar's most economically disadvantaged population in Madagascar. Santénet is helping MOH/FP

SANTENET 2005

An employee of a community-managed pharmacy checking the inventory of GED.

achieve this objective by providing technical assistance for the Equity Fund and for community-based health financing schemes, known as *mutuelles*.

First, the development of a governmental Equity Fund represents a financial mechanism by which the very poorest are allowed access to health services. Santénet assisted the MOH/FP's finance committee in designing the technical framework, developing eligibility criteria for the beneficiaries and identification methods, defining the service packages, and monitoring. The Equity Fund is being implemented at the BHC level, and the Government launched the "solidarity card" in June 2005 which gives cardholder free access to GED. However, Santénet continues to work with the finance committee of MOH/FP to introduce the system at all levels of services. Santénet thus provided technical assistance to MOH/FP for the development of the Equity Fund pilot project at the District Hospital level which will be funded through the World Bank.

Second, to further reduce economic barriers to accessing health care, especially financial barriers due to problems of seasonal cashflow, Santénet is exploring community-based health financing and insurance schemes, or *mutuelles*, which consists of collecting financial contributions from individuals or families and establishing a collective fund to finance necessary health services and products. *Mutuelles* are not a new concept in Madagascar, and one of Santénet's first tasks was to collect and analyze information about past and current experiences and capitalize on best practices and lessons learned. Based on these, Santénet then developed a guide for setting up and promoting a *mutuelle* in a given community. A draft version of the guide is being field-tested in Talata Ampano commune before it can be used to pilot *mutuelles* in other sites.

Optimize the 2004 HIAKA measles prevention/Vitamin A campaign and introduce the partnership on the local level. According to EDS III, two out of every five children are not completely vaccinated for childhood diseases. In this context, the control of neonatal tetanus and the certification of Madagascar as a polio-free country is a priority for the MOH/FP.

SANTENET 2005 (SETA)

The President of the Republic and the Minister of Health and Family Planning distributing health "solidarity cards" to the most needy in the Manjakandriana commune.

Santénet contributed to the design, planning, training, and supervision of the HIAKA (measles), FAV POLIO 2005 and the Vitamin A campaigns. These campaigns were conducted with the participation of a broad base of community and national support. Santénet contributed to the campaigns by financing the purchase and the national distribution of the storage and waste collection bags, and by assisting regional vaccination teams to conduct detailed planning, supervise, and officially launch the campaigns. The national measles campaign reached over 7.5 million children (nine months-14 years old), or 99 percent of targeted children.[6] Santénet also participated in the two rounds of the national polio campaign organized in response to five cases of acute flask paralysis of vaccine-origin in Toliara. The results of this campaign will be available in November.

Maintain and optimize USAID contribution to the coordination of routine EPI. The IACC promotes coordination of technical and financial support for the vaccination program. The IACC, led by the MOH/FP with high-level participation from other development agencies, is a forum for dialogue and technical validation. The IACC technical working group is composed of MOH/FP and partners' technical advisors. The technical working group implements the strategies determined by the larger IACC. In 2005, Santénet actively supported (EPI Inter-agency Coordination Committee (IACC) policy meetings and technical committee meetings to coordinate the implementation of routine immunization, as well as vaccination campaigns. Santénet participated in numerous subcommittees: the technical sub-committee, logistic sub-committee, and finances sub-committee.

Ensure the proper functioning of the cold chain in the project intervention areas. Madagascar is an immense country where logistics and communication are two great challenges for national-level interventions. An efficient cold chain is essential to immunization and vaccination activities as vaccines are sensitive products and lose their efficacy when exposed to extreme temperatures. Adequate equipment, compliant with national vaccination policy is pivotal for the success of the EPI program. A functional and efficient cold chain in the Malagasy context requires rapid mobilization and constant efforts from all stakeholders (vaccination department, SSD, BHC, partners etc.), as well as skills and knowledge of national technicians responsible for managing the cold chain.

As part of the ongoing training of the MOH/FP personnel, Santénet assisted in training supervisory personnel, conducted some supervision, disseminated basic EPI management tools (child health cards, mother health cards, tally sheets, and pre-report sheets), installed of EPI software in eight regions and in all the 111 SSD of the country. Electronic tools are used to guide vaccines managers in inventory forecasting, control and distribution, in the use of vaccines, and in the management and monitoring of EPI programs. These tools solve various operational problems: inaccurate forecasting, inadequate storage and control, ineffective distribution of vaccines, and dysfunctional cold chains. These tools also decrease rates in vaccine losses and stock-outs that affect the provision of vaccinations.

EXPANDING THE WHOLESALE AND RETAIL NETWORK FOR SOCIALLY MARKETED PRODUCTS (IR 2.2)

Develop a sustainable network for the distribution of socially marketed products. Work sessions held with PSI identified actions to undertake with NGO partners, to form a non-commercial network for socially marketed products and expand access to PSI health products such as ITNs, malaria treatment, and contraceptive products.

Build the capacity of private distribution network actors and NGOs to rationalize availability of socially marketed products. To increase the number of sales outlets for socially marketed products, Santénet's supported the private sector by working with Population Service International (PSI) to train community-based sales agents (CBSAs) and all implementing partners of "*Kôminina Mendrika* ". The training introduced the set of social marketing health products to CBSAs. The latter were trained to

[6] During the campaign, there were instances when the coverage rate exceeded 100%, calling into question the accuracy of baseline data/forecasting.

present and propose products as well as convey key health messages. This activity is undertaken jointly with PSI as part of its rural penetration strategy. An initial agreement on CBSA kits distribution was signed between PSI, SAF-FJKM and Santénet. Santénet provided technical and financial support to the expansion of the distribution network for socially marketed products and the training of 12 trainers and 130 CBSAs working in the healthcare facilities managed by SAF/FJKM. As a result of this collaborative effort, 1,953 ITNs, 4,454 Palustop blisters, 1,555 Sûr'Eau bottles, 1,300 Pilplan slabs and 1,300 condoms were distributed. Santénet and PSO then decided to expand the training to the other KM partner NGOs. Forty-three trainers from the latter took part in the training of trainers. 1,685 CBSAs were trained in product distribution and health education techniques for malaria control, family planning, STIs/AIDS and diarrheal diseases prevention. Each CBSA received a starter pack of the social marketing products. These newly trained CBSAs will be operational starting October 2005. Meanwhile, SanteNet contributed to increase from approximately 600 CBSAs to 2,400 , namely a increase by four times. This success is the result of constructive partnership among SanteNet, NGOs and PSI.

Analyze the social marketing product needs of the Inter-enterprise Health Care Alliance. Santénet carried out a needs assessment study at the Inter-Enterprise Healthcare Organization (OSIE) office in Fianarantsoa, which allowed Santénet to identify needs at a workplace level. Most of the needs identified by the study are company-based. Consequently, activities will be directed towards private companies and will be undertaken concurrently with the WorkPlace Initiatives (WPI) (see below).

SANTENET 2005 (SETA)

Providing better access to *Sûr'Eau*, a simple socially marketed water purifying system, contributes to better access to safe water for households.

Design an action plan to implement a social marketing program in private companies (Workplace Initiatives). For 2004-2005, the Santénet Workplace Initiative (WPI) drafted intervention strategies to address HIV/AIDS/STI prevention in the workplace. Santénet carried out a needs assessment study for the tea-making company "THÉ SAHAMBAVY" based in Fianarantsoa. The needs thus identified will be addressed under the WPI for private companies planned for Year 2 activities. Santénet worked collaboratively in the development of an HIV/AIDS strategy for the workplace. In collaboration with GTZ, Santénet also participated in the training of five large companies: BNI, Air Madagascar, STAR, Orange and Total. Over 100 people were trained during the training including peer educators, eight healthcare providers and 23 company executives.

INCREASING ACCESS TO PRIORITY HEALTH SERVICES FOR REMOTE POPULATIONS (IR 2.3)

Carry out community-based health activities in priority conservation areas. As mentioned under IR 1, Santénet has started implementing the community mobilization approach *Kôminina Mendrika* (Champion Commune) in 80 rural communes, 11 of which are located in priority conservation areas. In those 11 communes, the integrated health-environment KM approach will be implemented in collaboration with USAID's Ecoregional Initiative project.

Identify the obstacles to and opportunities for placing physicians in rural areas. The establishment of *mutuelles* will solve the problem of seasonal cashflow in rural communities, which is one issue which discourages the establishment of private health services in rural areas.

INCREASING THE NUTRITIONAL VALUE OF AGRICULTURAL PRODUCTS (IR 2.4)

No activities were implemented under this sub-IR. Please refer to the Activities Not Completed section.

IMPROVING WATER MANAGEMENT FOR AGRICULTURE AND HOUSEHOLDS (IR 2.5)

Improve the environmental hygiene and sanitation component (including promotion of the Sûr'Eau) through an integrated plan of action. Hygiene and sanitation activities are aimed at preventing endemic diseases such malaria and diarrheal diseases and improving water quality. For this year, Santénet's priority was to provide KM communes access to the to Sûr'Eau, the safe water system currently marketed by PSI. The KM partner NGOs will ensure this access through their CBSA who will promote Sûr'Eau as a cheap and practical way to improve hygiene and sanitation.

STI/HIV/AIDS

Support the update and execution of Condom Programming. Although the prevalence rate of HIV/AIDS in Madagascar is much lower than the majority of its African counterparts, the Government of Madagascar, through the ES/NACC, continues its efforts to contain the spread of HIV. One strategy will expand the distribution and increase the use of condoms. In 2003, the Condom Programming Group (CPG) developed a National Condom Programming Strategy that considers three main axes: (1) policy environment, (2) demand and use, and (3) procurement and access (logistics).

Santénet provided technical assistance to ES/NACC to update the strategy to better position the condom as a means to prevent STIs and HIV/AIDS. Although sales of condoms are increasing every year, they nonetheless remain low, with only 12 million condoms sold in 2003 for a population of 16 million. To do so, Santénet recruited two international consultants: Rudolph Chandler, responsible for identifying other potential supply networks, and Dr. Mamadou Seck, responsible for IEC/BCC strategies. The consultants made practical recommendations for the implementation of the updated strategy. , and as a result, ES/NACC is currently operationalizing the distribution logistics and carries out activities aiming at increasing demand to 15 million condoms for this year, with Santénet's continued support. In addition, the project provided technical assistance for

the validation at the national level of the new distribution networks of condoms, and for the development of a training curriculum for program implementation.

HIGHLIGHTS FROM SANTENET'S REGIONAL OFFICES

Fianarantsoa trains in FANOME. Santénet financed the training of BHC MC members in the Ambalavao health district in the Haute Matsiatra region in the effective use of FANOME. The training took place from May 23, 2005 to June 16, 2005. Four classes with a total 112 people from 28 health structures received the training. The training was provided by two EMAD of the Ambalavao SSD, who had been trained as trainers in early 2005. The participants were satisfied, because they now know what their respective role is in the use of the FANOME and in the BHC MC.

The FAV Polio campaign in Toliara and Fort Dauphin. Santénet's regional teams in Toliara and Fort Dauphin provided assistance to the Toliara Regional Health Division to ensure maximum coverage during the first round of the FAV Polio campaign (August 29 to September 2, 2005) in the province of Toliara, especially since that was the province where five cases of acute flask paralysis of vaccine-origin were diagnosed. Prior to the campaign, Santénet provided logistical support to transport all the necessary vaccines and the campaign monitoring tools down to the basic health centers throughout the province. During the campaign, Santénet provided transportation to district supervisors. After the campaign, Santénet will, as it does with all the mass campaigns it participates in, contribute to the evaluation.

Exploring community-based health financing and insurance schemes in Fianarantsoa. Santénet, with technical assistance from its consortium partner Medical Care Development International, is studying community-based health financing and insurance schemes in the province of Fianarantsoa. Following workshops organized in Fianarantsoa on health insurance, the Santénet Fianarantsoa regional office and the Haute Matsiatra District Health Services went to the Talata Ampano commune to work with the local mutuelle promoters to improve their management and bookeeping skills, based on the *mutuelle* guide. As a result, roles of the various stakeholders in mutelle management were clarified, specifically emphasizing the importance of developing productive, effective relationships between the *mutuelle* and public authorities and partners, including the BHC, MOH/DHS, RHD, the commune, and local NGOs.

IMPACTS FOR 2004-2005

Successful integration of contraceptives in GED public distribution system. Integrating contraceptives into the GED supply chain was successful in addressing district level supply problems. Monitoring the longer-term impact at district and site levels will be easier as the general supply monitoring system now includes contraceptive products, particularly the stocks of Depo Provera, which is Santénet's main indicator for stock-outs (*Santénet indicator 9*). The 2005 FP Logistics Survey scheduled for October 2005 will provide a more comprehensive view of the short-term impact of the integration.

Better managed EPI. Santénet's assistance in establishing computerized tools for vaccines, cold chain and data management contributed significantly to standardizing EPI logistics management. It also enhanced the capacity of public healthcare providers at all levels to conduct needs assessment, forecast needs for vaccines as well as equipment maintenance for the cold chain functionality, as well as for data analysis. These results relate to the indicator on the proportion of public healthcare centers equipped with a functional cold chain (*Santénet indicator 10*).

Joint efforts by all concerned partners to expand the distribution network of condoms. Santénet contributions to the Condom Programming have encouraged all stakeholders to expand the distribution network to increase condom availability (*Santénet indicator 4*). New outlets have been identified, such as public BHC, youth centers, information halls and infirmaries in army barracks.

Also, ES/NACC is currently making operational the distribution logistics and carries out activities aiming at increasing demand to 15 million condoms for this year.

Distribution network for socially marketed products expanded. Twenty-five communes where SAF/FJKM healthcare centers are established (including 130 sales outlets), and 81 *Kôminina Mendrika* (with 1,685 sales agents who were given starters' pack which will supply them with revenue to purchase more products in the future), have established a distribution chain for these products. These distribution chains have recently been set up, so there are limited sales figures available (see table below). The expansion of sales outlets for health products as well as the contribution of the private sector to malaria control, FP, child health and STIs/AIDS control contribute to *Santénet indicators 11 and 12*.

For the first 25 communes, sales for July to September were:

IMN	1,953
PaluStop	4,454
Sûr'Eau	1,555
Pilplan	1,300
Protector Plus	1,300

Better access to socially marketed products in remote areas. Santénet has initiated the *Kôminina Mendrika* approach in 80 rural communes and collaborated with PSI to train the community-based sales agents who will be selling socially marketed products. Out of these 80 communes, approximately 15 are quite remote, for example the commune of Miarinarivo in the province of Fianarantsoa, or the commune of Ambodimangavalo in the Toamasina Province: there are no main roads to the commune, and the only way to get there is by truck or by foot. Now, with the KM approach being implemented, Santénet and its partner NGOs will be able to increase access to socially marketed products such as PilPlan, Protector Plus, Sûr'Eau, Super Moustiquaire in those remote areas (*Santénet indicator 11 et 12*), and thereby better prevent malaria, diarrheal diseases or STIs, and promote family planning (*Santénet indicator 1*).

2004-2005 ACTIVITIES NOT COMPLETED

Supporting the integration of socially marketed products to the public supply chain. Santénet was not able to implement this activity because the World Bank Multi-country AIDS Program (MAP) did not receive the necessary funding to supply the products, Cura-7 and Génicure, planned for integration into the public supply chain.

Supporting Reach Every District (RED) EPI strategy. The strategy "Reach Every District" (RED) will strengthen districts with low vaccination coverage rates. It was deferred during 2004-2005, due to three major immunization campaigns that mobilized the national program and donors resources.

Support the Mobile Sanitary Team in service delivery and activity implementation Santénet was not able to implement activities related to the Mobile Sanitary Team due to organizational changes within the MOH/FP. Resources for this unit have been allocated to other MOH/FP priority activities, for example, setting up the Regional Health Divisions. To date, the Mobile Sanitary Team's activities have been put on hold.

Analyzing existing farming practices for their nutritional value and designing a small number of agricultural/horticultural micro-projects to improve nutritional status. This activity was supposed to be done with the assistance of Helen Keller International. However, because project resources for local-level activities such as this one, will be directed as much as possible toward the *Kôminina Mendrika* communes, and the communes were not finally selected until June 2005, the activity could not be completed this year.

Participating in the development of a strategy of installation of pre-positioned kits in areas prone to natural disasters. Santénet did not undertake this activity because it seemed to be an activity more appropriate for organizations working in emergency and crisis management, such as the Title II organizations. Furthermore, local partners, such as the National Rescue Council (NRC), were not involved. However, in the future, Santénet plans on attending regularly NRC meetings and provide assistance if requested and appropriate.

IR2 TIMELINE

SUCCESS STORY

Making Family Planning a Government Priority

USAID contributes to the social and economic well-being of the Malagasy population by promoting family planning

Viviane, 26, has benefited from the use of Norplant for 7 years. After their third child, she and her husband decided not to have any more children in order to give their current ones a better quality of life. "I want to be present for my three children, and having too many means taking care of the smallest, and often neglecting the oldest" she says. "Now I can develop a close relationship with all three, run a small shop, and earn money for the family."

Viviane, 26, had a traditional Malagasy wedding. Her father made the customary toast by wishing upon her seven sons and seven daughters. But when their third child was born, she and her husband both decided they did not want to have any more children in order to give their current ones a better quality of life.

For the past 12 years, USAID Madagascar has been responding to the needs of families like Viviane's throughout this island nation of 17 million. Over that time, efforts to help families space or limit child births have prevented 2,500 maternal deaths and 22,850 infant deaths each year[7].

Among those who have embraced the value of family planning as a way of saving lives and energizing the country's economic development and well-being is President Marc Ravalomanana. In 2003, his government changed the name of the health ministry to the Ministry of Health and Family Planning. Since then he has taken the importance of family planning to heart.

"Just think, if we now have four million women between the ages of 15 and 30, and each one of them has four children, in 10 years we will have 16 million more people," he told an international conference in January 2005. We must plan the number of children we have so the next generation can live with dignity[8]."

USAID's support for family planning in Madagascar includes training of health service providers, improved logistics and information systems, educational curricula, communications campaigns to promote natural family planning methods, community mobilization, and safer health practices through quality of care improvement. The Ministry of Health and Family Planning estimates that 517,000 births were averted over the past decade which contributed to a 15-percent increase in per capita resources available to Malagasy children under five.

Through a decade of persistent work, USAID has helped change the face of family planning in Madagascar. The culmination of all past efforts was a two-day national family planning conference in December 2004 in Antananarivo organized by several health organizations, including Santénet, the most recent USAID-funded health project. More than 300 people from all over the country participated, including President Ravalomanana who, by his presence, confirmed the need to reposition family planning among the priorities of his country for promoting social and economic development. The process succeeded in repositioning Family Planning strategy in Malagasy policy agenda at the same level as the fight against HIV/AIDS and the Roll Back Malaria strategy. The new evidence-based strategy is tailored to confront serious problem of unwanted pregnancy and/or unplanned fertility in Madagascar and promote informed and free choices of FP methods and sources of service providers.

[7] MOH/FPFP, New Family Planning National Strategy: Better Off Malagasy Families. Antananarivo, 2005

[8] Opening speech in Indian Ocean State Island conference, organized by the United Nations, January 14, 2005

CHAPTER FIVE: INTERMEDIATE RESULT 3 (IR 3)

IMPROVING THE QUALITY OF SELECTED HEALTH SERVICES

MADAGASCAR'S HEALTH CARE DELIVERY STRUCTURE

Madagascar's health facilities can be classified in three categories. The first category is composed of rural basic health centers that ensure the first contact and offer a minimum package of health. The second category is comprised of the regional reference hospitals (CHRR) and districts reference hospital (CHD2) that provide the complementary health package; the country has in total 22 CHRR and 23 CHD2. The third category includes the two University hospitals in Antananarivo and Majahanga . In addition, the private sector and the army run approximately 100 health centers for the army, 396 BHC for the private and religious organizations and 281 dispensaries for private enterprises. There are also private clinics which provide a whole range of health services.

This section describes the IR 3's activities for 2004-2005, as well as their impact. The experiences from the regional offices are also included, as is a timeline of activities.

INTRODUCTION TO THE INTERMEDIATE RESULT

To increase the demand and availability of selected health services and products, health services must meet the quality expectations of clients, which are often related to convenience, interpersonal relations and respect of individual rights. Clinical services must also be provided according to evidence-based standards and guidelines. Consistent quality of care across public, private and NGOs provider networks is essential for a coordinated national response. IR 3 addresses the development and the implementation of state-of–the-art service delivery practices through the *improvement of the quality* of health services at commune level and selected practicum sites in the 4 target provinces. Improved service delivery will contribute to the promotion of family planning, improvement child health, control of malaria and prevention of STIs including HIV/AIDS. In order to improve the quality of these selected services, the activities under IR 3 are designed to improve policies, standards and protocols (PSP) for public and private health services (IR 3.1), improve service providers' ability to deliver quality health services (IR 3.2), and implement operational models for quality assurance (IR 3.3).

Improve procedures, standards and protocols (PSP) for public and private health services (IR 3.1). Use of health services is highly dependent upon the quality of care provided. Quality is generally measured against accepted PSP. While some PSP exist for key child, maternal, and reproductive health programs, much needs to be updated and revised to comply with the best practices recommended and accepted internationally. In other cases, PSP need to be established.

Improve service providers' ability to deliver quality health services (IR 3.2). Another key area to improve quality of services delivered is through pre-service and in-service education for health professionals. Many existing PSP are not well understood by health providers and as a result, are not appropriately implemented. Medical and paramedical training institutes in Madagascar lack resources to upgrade their facilities. Furthermore, their curricula and

methodologies need to be updated as new PSP come on line.

Implement operational models for quality assurance (IR 3.3). Operation models are another mechanism by which improved services can be tested and validated. Furthermore, information from the models can ultimately be used at the national level to improve PSP. If proven successful, these models can be expanded to a larger scale by other donors.

2004-2005 ACHIEVEMENTS

IMPROVING HEALTH POLICIES, STANDARDS AND PROTOCOLS (PSP) FOR PUBLIC AND PRIVATE SECTOR HEALTH SERVICES (IR 3.1)

Support the review or development of health policies, standards and protocols. While Madagascar has developed norms and protocols for most technical health areas, they do not always reflect state-of-the-art thinking or current best practices recommended at the international level. To bring the PSP up to date and in line with international standards, PSPs are systematically being reviewed by the MOH/FP, with technical assistance from Santénet. Santénet provided technical and financial support to the development of the National Policy on Child Health, which is in the process of being approved by stakeholders. In addition, the national service for staff training and improvement (SFPP) team also received support to update the National Health Training Policy, which is also awaiting its finalization and approval. PSPs for Malaria including malaria prevention during pregnancy (MPP) have also been revised with the support of WHO to include new changes in malaria treatment and prevention; Santénet collaborated as a partner in the national Roll Back Malaria (RBM) coalition. The MPP document is awaiting approval.

Negotiations were started with the Ministry of Health in April 2005 to review the RH/FP policy and standards that was developed in 2002 but printed in 2004. UNFPA is supporting the review of the RH national policy through a consultancy with the National Institute for Public Health (INSPC) and Santénet was requested to revise in parallel the RH/FP National Standards and Protocols to include the missing components such as MPP and MTCT. Initial planning steps were undertaken, such as appointing the members of the technical national experts group as well as the focal point. These people are responsible for overseeing the revision process and providing technical reviews of the drafted revised documents. A meeting took place in August 2005 with the technical expert group to discuss its terms of reference (TORs) and work schedule. In the next year Santénet will finalize the RH norms and protocols for reproductive health, This work will be done in close collaboration with UNFPA, UNICEF, JICA and other partners concerned.

IMPROVING SERVICE PROVIDERS' ABILITY TO DELIVER QUALITY HEALTH SERVICES (IR 3.2)

Building the capacity of health providers is critical to improving service quality. A number of strategies have been adopted to improve the ability of service providers to deliver quality health services.

Improve Infection Prevention (IP) practices. Infection Prevention (IP) is key to reducing the spread of infectious diseases, including HIV, in a clinical setting. Assessment studies conducted by JHPIEGO and the World Bank revealed that IP practices in use in Madagascar are very low at every level of the health system.

In collaboration with the MOH/FP Santénet undertook a rapid assessment of infection prevention (IP) practices in 11 sites which represented various types of health facility in Madagascar (teaching hospitals, pilot sites, BHCs across the four provinces). The results of the assessment revealed that the majority of service providers had some level of knowledge about IP principles but that there were behavioral gaps in three key areas: hand washing, instrument handling and waste management, and lack of equipment and IP materials. Santénet then conducted a series of training workshops to update the IP strategy using MOH/FP0-approved curricula targeting different categories of health professionals. A total of 98 people

received training in IP practices. The participants also developed IP action plans, which they agreed to implement once they return their respective place of work. Santénet monitored the implementation of good IP practices at training sites for one month, with assistance from the MOH/FP.

Train and qualify trainers in Clinical Training Skills (CTS). Twenty-two CTS candidates were selected by regional and central level health officers. The candidates received five days of training facilitated by JHPIEGO technical specialists, Dr. Tiemoko Ouattara and Dr. Tsigue Plëah. Ninety-one percent of candidates were subsequently qualified as IP trainers (only two people were not qualified).

Provide training in advanced training skills (ATS). In June 2005, 25 candidates to the ATS training (5 at central level, 11 regional supervisors, nine intern monitors) were selected among the candidates qualified in CTS by managers at central and regional levels. The candidates followed a five-day training program delivered by the JHPIEGO team (Pr. Yolande HYJAZI and Dr. Tsigue PLËAH). They will be qualified during the CTS workshops for managers at district and KM BHCs' levels.

Introduce the Standard Days Method of natural family planning. To expand the range of FP methods available in Madagascar, Santénet is exploring the viability and feasibility of introducing the natural family planning method known as Standard Days Method (SDM). Santénet developed an operational research study with the Institute for Reproductive Health (IRH) of Georgetown University to assess the acceptability of the method in Madagascar and design ways to increase access to SDM. The research was undertaken in 27 medical centers and involved four national NGOs and the MOH/FP.

A Standard Days Method training of trainers was led by the team of IRH consultants from Georgetown University RHI (Dr. Arsène Binanga and Ms. Marie Mukabatsinda). Santénet provided technical, logistic and administrative support for trainings for SDM service providers, conducted in collaboration with the MOH/FP, SALFA, SAF/FJKM, ADRA and the Association of Catholic Physicians of Madagascar. In addition, sensitization workshops were held for community mobilizers in the research sites. 26 physicians, 12 paramedics and two FP counselors acquired knowledge and skills related to SDM. A total of 46 community organizers received information on SDM as part of the community outreach.
To date, 26 sites are delivering SDM. 135 couples report using SDM as a

SANTENET 2005

Health service providers are being trained on simple ways to reduce the spread of infectious diseases, such as cleaning instruments using soap water.

contraceptive method, 76 of whom are new users of family planning.

Provide support to ADRA "MAHATOKY" Toamasina. ADRA's "MAHATOKY" project in the city of Toamasina aims at improving the quality of family planning services in the health centers of the Toamasina I MOH/DHS by organizing training workshops for service providers and community organizers. In 2004-2005, Santénet and ADRA MAHATOKY co-financed a series of eight training sessions for 20 service providers on the following topics: technical supervision, training of trainers in curriculum development, family planning, Fixed Days Method (FDM), GIS/FP, STIs/AIDS prevention, Infection Prevention and FP counseling. One ADRA staff member was actually qualified as IP master trainer.

IMPLEMENTING OPERATIONAL MODELS FOR QUALITY ASSURANCE OF SELECTED HEALTH SERVICES (IR 3.3)

Given the long process of developing and updating PSP, Santénet worked on the intermediary goal of developing desired performance standards for RH/FP, STIs and Focused Prenatal Care/Malaria Prevention during Pregnancy (FPC/MPP) in collaboration with the MOH/FP and the Malaria Action Coalition (MAC) project in 2005. The development of desired standards should accelerate the standards and protocols update process in for the targeted technical areas. MOH/FP approved the standards, which allowed Santénet to introduce the PQI approach in 11 practicum sites.

Introduce the PQI approach at practicum sites. The Performance and Quality Improvement (PQI) approach was introduced in March 2005 through a guidance and advocacy workshop. Thirty-three central and provincial health officials from the MOH/FP and key Santénet partners participated, along with representatives from the 11 selected practicum sites. Approximately 80 participants took part in the advocacy and were sensitized on the approach.

A workshop followed to define desired performance standards for FP and STIs/HIV prevention. Forty-eight participants from practicum sites and training institutions as well as officials from the former Provincial Health Servce and the ES/NACC participated actively in the exercise and contributed to the elaboration of the standards documents. A second workshop was held to develop desired performance standards related to FPC/MPP, with 28 participants in attendance. A document was prepared and will be put at the disposal of service providers at MAC project's sites. The desired performance standards for FP, STIs/HIV and FPC/MPP represent an evaluation tool to describe the current situation of health services at practicum sites and selected MAC project sites. An evaluation tool was designed to measure performance level, which was then used by the eleven sites to analyze their existing performance levels for FP/STIs/HIV over three months, with support from the IR 3 team. Representatives from the MOH/FP (central level and DPS PF) participated actively in this activity.

Consultants from JHPIEGO facilitated the analysis workshop which examined the gap between existing and desired performance levels for FP and identified of actions to bridge the gaps. The Santénet team then facilitated the remaining series of analysis and action plan workshops for the remaining sites. Santénet provided technical support to MAC project for the analysis workshop for FPC/PMP in Toamasina. At the end of each workshop, the 11 sites had developed an action plan to bridge these gaps. Officials from the MOH/FP at central regional and district levels, maternity and BHC heads, managers/administrators and service providers also attended the workshop. These analyses also highlighted the logistics needs of the health centers, and in response 11 BHCs received IP materials and personal protection equipment from the MOH/FP. Santénet also approved request from the 11 sites and purchased a series of IP materials to support the improvement of IP practices, These materials include dustbins and individual protection materials (masks, gowns, aprons, caps, and boots). In the other hands, monitoring visits were carried in all sites to assess the progress so far made.

After the workshop on the analysis of the primary causes, the health centers realized the need for refresher training in IP for the whole staff. Four refresher workshops were organized in four practicum sites, in which 98 percent of

the staff took part. The CSMI Tsaralalana did likewise by conducting a workshop attended by 56 percent of its staff. Santénet is currently trying to address requests from practicum sites and training institutions (supply of waste bins, examination gloves, plastic aprons, caps, etc.) . Santénet provided further financial and technical support (materials for practical demonstrations, technical documentation, supervision) during IP training organized by health centers for all their staff. JHPIEGO also provided a series of didactic materials on reproductive health and training technical issues including CDs, videocassettes and other learning and self-teaching documents for distribution in training institutions in Antananarivo and the other provinces. More requests are being received at Santénet from the private sector for training in IP and for financial support.

There are 138 BHC located in the 81 *Kôminina Mendrika* communes, of which Santénet selected 40 for the initial introduction of the PQI approach.

Introduction of the PQI approach and certification of "Quality BHC" within Kôminina Mendrika. Santénet launched the *Kôminina Mendrika* approach this year and developed with its partners the strategies of intervention aimed at promoting community mobilization, improving the quality of care delivered to the population, and improving access to and increasing demand for quality care. Improving care quality is based on the introduction of the PQI process into the KM BHCs in collaboration with the MOH/FP.

A preliminary project document on PQI introduction approach and "Quality BHCs" certification within KM communes was elaborated and submitted for comments to relevant officials within the MOH/FP. Field visits were undertaken to inform the administrative authorities in the communes concerned, the technical agents with the MOH/FP as well as the BHCs on the PQI process and "Quality BHC" certification. The visits also provided an opportunity to analyze the current situation of the BHCs covered by the certification process. The next step will be the training of Technical Evaluation Teams. In addition, the performance standards used for the practicum sites were reviewed and streamlined to respond to the needs of the KM BHCs that are less developed.

STI/HIV/AIDS

Santénet intends to contribute to documenting best practices on voluntary counseling and testing (VCT) for STIs. All the stakeholders involved in VCT and STIs prevention have been identified. The consultant's TORs and the survey tool have been elaborated and submitted to the MOH/FP for validation, however the STIs/AIDS Control Program indicated that this activity is already underway and Santénet would be requested for further support when the needs arises..

HIGHLIGHTS FROM SANTENET'S REGIONAL OFFICES

Performance and Quality Improvement in Fort Dauphin. The Fort Dauphin region was identified as a priority region since it will be a strong development pole with the interventions of QMM in the coming years. All BHCS in Fort Dauphin will be selected for the PQI. Santénet initiated at the early stage a few visits to provide guidance on the Performance and Quality Improvement (PQI) process for health agents with Fort Dauphin's SSD and BHCs, and partner NGOs staff (ASOS and CARE) The BHC of Fort Dauphin and the ASOS dispensary were selected as PQI practicum sites in Fort Dauphin and a rapid assessment study on IP was carried out in these two sites Then a PQI workshop was organized to define the desired performance standards related to family planning, sexually transmitted infections and HIV (FP/STIs/HIV) for the SSD of Fort Dauphin< A report on the current performance of the BHC of Fort Dauphin was prepared by the two interns fielded to Fort Dauphin; identification of interventions needed to bridge gaps, in particular infrastructure and equipment needs for the BHC of Fort Dauphin, with the assistance of a Peace Corps volunteer from Moramanga was also done.

2004-2005 IMPACTS

Effective application of health services standards and guidelines. The National Policy on Child Health has been developed and validated; the same applies for National Policy on Malaria Prevention during Pregnancy (MPP) that has been produced and its validation is underway and the National Training Policy is being finalized. The update process for the National Policy on Reproductive Health is under UNFPA responsibility and the work process on the revision of RH Standards and Protocols has effectively started with Santénet who is planning to finalize this in early 2006. It is expected that all concerned partners (UNFPA, UNICEF, JICA and other NGOs) will join efforts with disseminating new norms and protocols to health providers at every level of the health systems. With a good supervisory system, this will ensure the effective application of health services standards and guidelines. In addition, PSP update will help standardize all health interventions in Madagascar in compliance with international standards. The updated PSPs will be used as reference tools when updating other didactic documents. (*Santénet indicator 16*)

Better infection prevention. The reinforcement of 98 IP service providers' clinical skills and 23 physicians' clinical training skills and advanced training skills took place during participatory workshops using the andragogic approach. The workshops were led with the assistance of national as well as international resource-persons. The MOH/FP now has a pool of trainers capable of building the capacity of service providers in various technical areas, particularly infection prevention; most of them are being used during national or provincial /districts training workshops; Santénet is also receiving more requests for assistance in IP training from the public and private health sectors. These trained supervisory doctors and training institutions monitors will be able to more effectively monitor medical students and student nurses/midwives at practicum sites and more effectively teach at the training institutions.

As indicated in the reports of visits in the health practicum sites, the trained service providers initiated many changes in the IP practices in their respective center upon their return, as most of the trainees were health centers managers. Using their small income generated through cost-recovery mechanisms (FP service provision), they were able to provide appropriate chlorine dilution, do a systematic decontamination of instruments, promote more regular hand washing with individual towels, and organize better screening and collection of hospital wastes and build of incinerator. As a result, the implementation of the IP action plans highlighted the efforts and determination of managers and service providers to improve their IP practices. The majority of the activities planned are completed. They did their best to implement the action plan through resource mobilization, advocacy, and negotiation with their direct supervisors. The improvement is noticeable: the target

sites are cleaner, instruments are appropriately handled, and waste is adequately managed.

Range of contraceptive methods expanded. The SDM mid-term evaluation demonstrates couple satisfaction with SDM, and a high level of knowledge and skills among service providers and community organizers. With the introduction of SDM, the range of contraceptive methods available for clients is widened, and service providers and community organizers are able to deliver quality FP services (S*anténet indicator 1*).

Bridging quality gaps. The introduction of PQI approach in 11 practicum sites helped bridge gaps in quality FP and STI services. By implementing their action plans, these health centers will be able to comply with more desired standards, and the performance and quality of care delivered will thus greatly improve. (*Santénet indicator 18*). The PQI approach involves a continuous process. Regular evaluation of the progress made will take place every 3 months.

2004-2005 ACTIVITIES NOT COMPLETED

Provide assistance for the revision of training curricula. Santénet had planned to provide technical assistance to training institutions for the revision of training curricula in FP, STI and MIP. However, this activity was not completed because it has proven difficult to organize work sessions where all key stakeholders can be present given their individual schedules and the various training activities that they are participating in. Instead, Santénet devoted its efforts to developing the competency of a pool of trained group of people at national and provincial level capable of developing a curricula. The FP curriculum revision will be done in November by this group and the revision of PCIME and Nutrition curricula will start in early 2006. Revision of the MIP training curriculum will be done during the last quarter of 2005 with the support of WHO and JHPIEGO under the MAC project.

SANTENET 2005 (SETA)

A woman interested in the Standard Days Method is being shown by the doctor in her local health center how to use the Cycle Beads.

IR3 TIMELINE

SUCCESS STORY

Better health through better hygiene

USAID helps prevent infections in hospitals and health centers in Madagascar

Staff members of the Itaosy hospital are working hard to improve the hygiene in their work place, and thus prevent the possible spread of infectious diseases. They have set up an infection prevention station where someone is now responsible for preparing the chlorinated and soap water to wash hands and clean instruments (top), while another person is responsible for burning waste in the incinerator funded by the WHO.

Infection prevention (IP) is fundamental to reducing the spread of infectious diseases and the potential risk of transmitting HIV to health care staff and clients and the community in general. Assessments prepared by JHPIEGO and the World Bank showed that infection prevention practices in Madagascar needed strengthening at all levels of the health care system. To do so, USAID Madagascar has put in place the Performance and Quality Improvement (PQI) approach.

During the months of January and February 2005, USAID trained 98 health workers: doctors, nurses, midwives and assistants. They were trained in simple, and yet often neglected, topics such as hand washing, how to handle and clean instruments, how to keep the workplace clean, and waste management.

Solo Voahangy Nirina, one of the 98 health workers trained, is the chief nurse of the hospital CHD2 Itaosy. She has shared what she learned during the training with her colleagues, and she and her team have worked hard to apply IP standards. They have created a committee responsible for ensuring that the staff applies IP standards and finds simple solutions to existing problems. They have also set up an IP station, and although they have never used bleach in the past, someone on the team is now responsible for preparing the chlorinated water and soap water on a daily basis and distributing it to her department, as well as the rest of the hospital. The World Health Organization decided to use the hospital as a pilot site for an incinerator.

The Santénet PQI approach is based foremost on assuring that service providers apply infection prevention standards. This practical approach will prepare providers, managers and students to comply with rules and directives when practicing medicine. Improving performance and quality is essential to enhancing service providers' ability to provide quality service as well as implementing operational quality assurance models for specific health services.

CHAPTER SIX: INTERMEDIATE RESULT 4 (IR 4)

IMPROVING THE INSTITUTIONAL CAPACITY TO IMPLEMENT AND EVALUATE HEALTH PROGRAMS

This section describes the activities accomplished under IR 4 in Santénet's first year of implementation. This is followed by a description of the impact of these activities. Selected regional activities are highlighted within the section, which ends with a graphic timeline of activities conducted from June 2004 to September 2005.

INTRODUCTION TO THE INTERMEDIATE RESULT

In general, IR 4 activities consist in strengthening the health system and supporting the civil society and NGOs in the implementation of health activities which promote family planning, improve child health, fight malaria, and prevent STIs, including HIV/AIDS. *Improving institutional capacity* consists in improving data collection and use for decision making (IR 4.1), expanding access to health information (IR 4.2), improving the capacity of NGOs to implement health programs (IR 4.3) and increasing the capacity of the civil society to advocate for public health issues (IR 4.4).

Improve data collection and use for decision-making (IR 4.1). Madagascar's health information system primarily provides statistics rather than surveillance data and is far removed from disease control efforts. There are multiple disease tracking systems with differing reporting requirements and surveillance methods. Reporting procedures are inconsistent and quality of data is poor due to misunderstanding of case definitions for many diseases. Detection and reporting of cases and epidemics is slow and largely ineffective. It is thus necessary to improve data collection and use by the Government of Madagascar for developing or revising program planning and implementation.

Expand access to health information (IR 4.2). Decentralized public sector entities and NGOs often lack access to adequate information to plan, conduct and evaluate their efforts in improving health. Access to information will

empower local authorities to better organize, manage, implement and monitor health initiatives, as well as advocate for their right to services and better prepare them to play an active role in decentralized social service provision.

Improve the capacity of NGOs to implement health programs (IR 4.3). NGOs operate networks of clinics and health centers throughout the country that provide a substantial portion of healthcare in Madagascar. The Government of Madagascar will continue to rely on NGOs to supplement the public healthcare system, making it imperative to strengthen NGO capacity to implement quality health programs. Furthermore, experience in Madagascar has shown that in addition to health organizations, non-health organizations, such as conservation, agriculture, women's and community groups also effectively promote key health messages, provide referrals to the nearest health centers, and advocate for health services.

Increase the capacity of the civil society to advocate for public health issues (IR 4.4). Civil society organizations, such as those mentioned above, need to build their capacity to advocate effectively on behalf of their constituents.

MADAGASCAR'S HEALTH INFORMATION SYSTEM

The HIS regroups all the mechanisms used to share information between all the levels of the health system for decision making. Among the different mechanisms, or sub-systems, is the Health Information and Management System (HMIS), whose purpose is to collect, analyze and share health data through all the levels of the health system periodically. The main tool used is the Monthly Activity Report (MAR). In 1998, the role of the HMIS was redefined and its new objectives were to contribute to the decentralization and autonomy of health districts by improving decision making and activity programming at the local level.

2004-2005 ACHIEVEMENTS

IMPROVING COLLECTION AND USE OF DATA FOR DECISION MAKING (IR 4.1)

Diagnose the existing Health Information System (HIS). The establishment of new policies and strategies are now all working to fight poverty and achieve rapid and sustainable development. New policies and strategies include the Poverty Reduction Strategy Paper (PRSP), the Millennium Development Goals (MDG), the National Nutrition Policy (NNP), and more recently the National Child Health Policy (NCHP). These new policies and strategies need reliable monitoring and evaluation indicators in order to evaluate performance against objectives.

Santénet provided support to the MOH/FP to assess the current state of the Health Information and Management System (HMIS) and its relation to the current health system objectives and strategies, which have shifted since the creation of the MAR six years ago. This evaluation was carried out in 10 health districts. An ascending and participative methodology was used, and all BHC district-level HMIS managers participated, as did regional and central level officials and technicians. The evaluation results were shared with all partners and stakeholders, and highlighted five key points: 1) The system needs to be updated and adapted to reflect current health policy strategies; 2) different stakeholders have different ideas of what information is important to gather and analyze; 3) district and peripheral level stakeholders do not use data in decision making and planning; 4) information generated does not meet the needs of local and national level users; and 5) information gathering requests are not coordinated at the central level, causing multiple requests for the same information and creating more work for district and BHC level workers. The MOH/FP officials, with Santénet's support, organized workshops to update the HMIS/RMA and data use, to harmonize routine and punctual data collection, and to develop a national HMIS policy. The MOH/FP departments, services and program leadership, and representatives of private entities and of the national and international partners participated in these workshops, with logistic, technical and financial support from Santénet. In all, 11 meetings were organized, with a total of 241 participants.

Revitalize the information system through four pilot sites (one site/province). To improve data-for-decision-making at a district level, Santénet supported the MOH/FP in the design of tools for the analysis and use of local health information for decision-making. The "Chartbook" is a graphic representation of BHC monthly data. It serves as a gauge of indicators for the BHC which displays a monthly action plan according to changes in the BHC indicator values. The diagrams will be shared on a regular basis with local authorities in order to include them in decision-making regarding health promotion in the commune. The chartbook approach is a low-technology way to allow BHC managers and community leaders to

effectively collect and analyze data to make appropriate decisions about resource allocation and prioritizing health activities. Templates, tables and instruction manual for the chartbook are ready for use. The chartbooks will also be introduced in KM BHCs.

EXPANDING ACCESS TO HEALTH INFORMATION (IR 4.2)

Contribute to the dissemination of the Demographic Health Survey (DHS) results. The main goal of decentralizing health services is to make them more efficient and more in tune with the needs of the population. One of the key elements of decentralized management at the provincial and regional levels is information management. To this end, the MOH/FP and INSTAT, the national statistics institute, led a Demographic and Health Survey (2003 DHS). The results of this survey cover the subjects of maternal and infantile health, family planning, nutrition, malaria, STI and knowledge on HIV/AIDS. The INSTAT and MOH/FP, in cooperation with the technical and financial partners, planned a series of workshops in peripheral areas to disseminate the results of the enquiry and to reinforce the use of demographic and health information by the provincial teams at various levels and in various sectors.

The objectives of the dissemination activities were to analyze and interpret provincial DHS data, using survey indicators, monthly activity reports and other information tools (focusing on FP, EPI, Nutrition program) to formulate actions to be undertaken for FP, EPI, and nutrition programs in the regions. Participants at these two-day workshops included decision makers, local political-administrative authorities and opinion leaders. These decision makers will be able to influence and raise the awareness of the population concerning the problem, in particular concerning the current state of health in order to determine the priorities and decisions to be made. Santénet provided financial and technical support to the MOH/FP in preparing and organizing meetings held in five provincial capital cities and four major towns, which were attended by a total of 501 people. This activity was co-financed with UNFPA, CRESAN and UNICEF.

IMPROVING NGO CAPACITY TO IMPLEMENT HEALTH PROGRAMS (IR 4.3)

Harmonize approaches and tools. This activity facilitates NGOs' ability to successfully implement their health programs. Discussed in greater detail in chapter IX, Santénet utilized its special activity fund to contract with local entities to implement *Kôminina Mendrika* for the first year. The contracting process developed NGO organizational capacity, which required that bidders comply with instructions in the request for proposals, respond to technical and financial questions from Santénet, and negotiate, finalize and sign contracts and grants.

Santénet also entered into a partnership with the International HIV/Alliance to work with organizations implementing AIDS projects with CNLS/MAP funding. In partnership with HIV/Alliance and ES/NACC, Santénet provided a guide for facilitating community-level discussions about STIs for 150 NGOs. The guide contains facilitation tools and exercises for the use by community organizers to address issues about the prevention of STI and HIV/AID. The guide, translated into Malagasy and disseminated nationwide, helps NGO fight against HIV/AIDS during awareness-raising activities.

Support MOH/FP in developing the national health contracting policy. The National Health Contracting Policy (NHCP) improves service provider performance by establishing a contractual relationship, which links achievement of performance objectives with resources. This relationship ensures greater accountability at the service provider level, and allows them to be more responsive to the needs of local population. Santénet participated in the development of the NHCP, in preparatory workshops, in drafting the document, and in the approval process. The NHCP Policy Paper records a first consensus on this increasingly important issue, which will be continuously adapted based on experiences.

INCREASING CIVIL SOCIETY'S CAPACITY TO ADVOCATE FOR PUBLIC HEALTH ISSUES (IR 4.4)

Increase civil society's capacity to advocate for health issues in the four provinces of intervention. The Country Coordinating Mechanism (CCM) is designed to coordinate all activities relating to Global Fund financing. Forty percent of the representatives in the CCM Madagascar come from the nongovernmental sector. Santénet contributed to the election of representatives from international and national NGOs.

After a highly successful meeting between the U.S. Ambassador in Madagascar and Malagasy religious leaders, USAID wanted to more effectively harness the power of religious organizations as a communication vehicle to convey health messages. In response, Santénet helped to establish a "religious platform" for health (namely, fight against HIV/AIDS/STI and implementation of the family planning strategy). The platform is made up of 17 denominations. The platform has developed its standard operating procedures, as well as a concept paper for a FP project in order to secure funds from Flexible Funds. The concept paper proposes to associate religious organizations to FP IEC/CCC activities, in particular increasing men's involvement in FP activities. They have also developed a proposal for HIV/AIDS/STI project, which is awaiting funding.

STI/HIV/AIDS

Contribute to the national forum on the HIV/AIDS. Each year, CNLS organizes a national forum to discuss AIDS-related themes; for 2005, the theme was AIDS and Religion. Santénet provided financial support to prepare IEC tools used during the forum and helped to select particular discussion topics. The forum also allowed organizations to share their experiences in the fight against STI/AIDS. Santénet's contributions to the AIDS and Religion forum allowed the ES/NACC to reach 400 religious leaders and request their greater involvement in the fight against HIV/AIDS. Thereafter, a platform was created to define the religious communities' contributions to HIV prevention, and psychosocial and pastoral support for PLWHA. 17 religious entities are founding members of this platform.

SUPPORTING THE IMPLEMENTATION AND REINFORCEMENT OF NEW STRUCTURES TO COORDINATE AND IMPLEMENT THE NATIONAL NUTRITION POLICY (NNP) (IR 4.6)

Support the development of the NNP's action plan and the terms of reference for the National Nutrition Council (NNC) and the National Nutrition Office (NNO). Santénet participated in the development of the national nutrition policy and the national nutrition action plan. Santénet provided support for the institutionalization of the National Nutrition Office and of the National Nutrition Council.

HIGHLIGHTS FROM SANTENET'S REGIONAL OFFICES

Nutrition activities in Toamasina. As regards the implementation the National Nutrition Policy, Santénet contributed to the action plan and the terms of reference of the National Nutrition Council (CNN). Santénet provided logistic support to the participants for the approval workshop for the National Nutrition Policy in Toamasina.

IMPACTS 2004-2005

Buy-in by all stakeholders for improved health data collection and analysis. The activities are cross-cutting activities, which simultaneously reinforce all health strategies and technical focus areas. The participative meetings which designed the analysis and updated HIS tools integrated many stakeholders at all levels of the health structure. They stimulated buy-in from the local structures and raised awareness on the importance of data and indicators. Improved HMIS tools allow a better use of data at all

levels: within the health structure, including BHC (*Santénet indicator 21*), by the community, especially in the KM communes, and by partners. The first year of the project was devoted to assessing the performance of the health information systems, and to modify data collection tools and procedures. These steps were successfully achieved. Starting from the second year, use of new tools will be introduced in KM health centers. Clearly, all these activities aim at a better data quality (*Santénet Indicator 20*).

A sustainable Health Information System under the leadership of MOH/FP. The MOH/FP has been the leader in the design and development of the Chartbook shows MOH/FP's determination to not only improve data collection and analysis tools for better use and decision making (*Santénet indicator 21*), but also to establish a sustainable system.

Improved access and use of health information for better health programs design. Dissemination of the DHS provided information for use by local and national health officials and authorities, administrative authorities such as mayors, regional and district heads, and private sector partners. At the end of each workshop, the annual work plan for each health district and region was updated in light of DHS information and based on workshop recommendations for maternal and child health activities. This activity will have an impact which would facilitate the introduction of the "chartbooks" concept (*Santénet Indicator 20*).

NGOs capacity building. The provision of the International HIV/AIDS Alliance guide provides a powerful tool which will allow NGOs to better communicate and facilitate discussions at a community level to discuss prevention of STIs, including HIV/AIDS activities. The successful completion of the RFP process for KM has given many NGOs their first experience in a competitive bidding process; this will allow them to pursue more funding opportunities and teach them the flexibility to adequately respond to the requirements of different donors. The NHCP expands the scope of health actors and will improve the health system by linking performance objectives with the necessary resources, resulting in an analysis of the real needs of the population. In the end, a health system which is more efficient and takes into account the needs of the people leads to an improvement in the health of the population in general.

Involving religious organizations in FP and HIV/AIDS activities similarly engages an actor which has previously been less active in FP and HIV/AIDS in Madagascar.

Civil society's capacity for advocacy. The platform of religious institutions is becoming operational, with drafting of the Flex Fund concept paper. The platform represents a powerful advocate for family planning and HIV/AIDS activities in Madagascar, with the help of Santénet which was instrumental in the development of a FP concept paper. Its members recognize the importance of uniting several religious entities and the power they have. Other religious entities have expressed interest in joining the platform. The ES/NACC and USAID recognize the importance of the platform proposing to use it in the FP strategy

2004-2005 ACTIVITIES NOT COMPLETED

Update PROFILES analysis. USAID project Linkages has taken over this activity.

IR1 TIMELINE

SUCCESS STORY

Better Access to Healthcare

USAID contributes to better access to healthcare thanks to the "*Mutuelles de Santé*"

Marie Odette Rasoavololona, 30 years old, married with four children, a member of the Talata Ampano mutuelle, was hospitalized before the mutuelle was created. She had to pay about 150,000 Ar (about $75)– two and a half months of earnings — for this hospital care. Odette's sister, Berndadette Ratoandro, 40 years old, married with six children, also had to be hospitalized for the same reasons But Bernadette was able to benefit from the mutuelle and owed nothing. "If the mutuelle had not taken care of things, I would have had to sell rice fields or other investments to pay for my hospital stay," she said.

The Bamako Initiative (BI) brought about drastic changes in the financing of health systems in sub-Saharan Africa. Like other African countries, Madagascar ended free delivery of Essential Generic Drugs (EGD) in public structures in 1997, in order to establish a cost recovery system. The reform of the organization and financing of the health system initiated by the BI certainly contributed to make EGD available in a sustainable way.

In 2005, equity funds made it possible for the poorest chunk of the population to access EGD in the basic public health structures. However, for a great part of the population, in particular in rural areas, financial accessibility to EGD and health services is tied to harvest seasons.
The inhabitants of Talata Ampano, a rural district in the suburbs of Fianarantsoa, organized themselves with the technical support of Santénet and the Regional Office of the Ministry of Health and Family Planning, and set up a private health insurance structure based on risk-sharing – known as *mutuelles de santé*.

Today, the private health insurance organization of Talata Ampano has over 8,000 members in an area of over 12,000 inhabitants, and gives access to a certain number of services in BHCs and referral hospitals, and also covers medical evacuation. The health insurance organization provides coverage during the eight-month lean period, during which the population generates very scarce incomes. It is managed by an executive committee elected among the community members.

As a result of the Bamako Initiative, some social categories maintained their benefits: soldiers in the army's health service, private sector employees, and civil servants. These three social categories receive financial resources from their employers or the Government to cover the cost of services delivered by the public service. Other services covered by programs remained free (treatment of tuberculosis and leprosy, immunization).
On the other hand, the great majority of the population, composed of the very poor (rural, unemployed, workers in the informal sector and retired employees) have to pay out the totality of fees directly to PHAGECOM, i.e. at the district hospital.

CHAPTER SEVEN

MONITORING AND EVALUATION

According to Santenet's Performance Monitoring Plan, this section reports the information collected in order to check on how project activities are progressing during the first year. Information analyzes the situation, determines whether the inputs in the project are well utilized and ensures all activities are carried out properly and are in time. The following tables provide judgment on what a project or program has achieved in relation to activities planned and overall objectives.

Indicator number	Indicator	Definition	Planned	Actual	Comments
Strategic Objective : Increased use of Selected Health Services and Products and Improved Practices					
1	Contraceptive prevalence rate	Proportion of women in union age 15-49 who are using (or whose partner is using) a modern method of contraception. Modern methods include oral contraceptives, injectables, implants, male condoms, IUD, male and female sterilization, vaginal foaming tablets.	19.3%	N/A	The 2005 targets are based on data from the 2003-200404 DHS and from the 2004 BSS. Proposed annual increases arederved from past experiences of USAID projects and other partners
2	DPT 3 coverage	Proportion of children aged 12-23 months who received the full series of immunizations for Diphtheria, Pertussis, Tetanus before age 12 months	63.3%	N/A	
3	Vitamin A supplementation coverage	Proportion of children aged 6-59 months who received a high dose (6-12 months: 100,000 IU; 12-59 months: 200,000 IU) of Vitamin A supplementation in the last six months	76%	N/A	
4	Condom use at last sexual rapport with a paying partner among youth and commercial sex workers	Proportion of "high risk people" using condoms during the last sexual rapport with a paying partner. "High risk people" include youth aged 15-24 (men, women) and commercial sex workers Paying means any form of remuneration including gifts, money, food, protection etc	Women 15-24 = 20%	Women 15-24 = N/A	
			Men 15-24 = 24%	Men 15-24 = N/A	
			CSW = 76%	CSW = N/A	
5	Exclusive breastfeeding rate	Proportion of infants under 6 months who are being exclusively breastfed. Exclusive breastfeeding is the practice of giving only breast milk to the infant, with no other solid or liquids, including water.	67%	N/A	
IR 1: Increased Demand for Selected Health Services and Products					
6	Number of communes utilizing the *Kôminina Mendrika* [KM] approach that achieve health objectives	Number of communes in Santénet intervention communes that have obtained "Champion Commune" status. The criterion for obtaining this status is: commune must meet the defined objectives for its selected indicators within a set time period.	Development of concept model and technical framework for Santénet Champion Commune approach.	New technical approach drafted in February 2005	
			Development of tools to implement the Champion Commune approach: social marketing kit; mass media/radio kit and interpersonal communication kit, including the trainer's guides for community-based agents.	Marketing tools, outreach tools and mass media tools for *Kôminina Mendrika* developed in September 2005	
			Competitive selection process for local and international partners for implementation of Santénet Champion Commune	request for proposal published in February 2005 4 subcontracts with international NGOs and 11 grants with the national NGOs signed between june and October 2005	

Indicator number	Indicator	Definition	Planned	Actual	Comments
			Implementation of the approach in **80** communes in the selected partners intervention areas	Implementation of *Kôminina Mendrika* approach in 80 communes in the provinces of Toamasina, Fort Dauphin, Antananarivo , Fianarantsoa and Toliara in September 2005 Training of trainers in IEC/CCC for 290 support technicians conducted in August 2005	
7	**Availability of IEC/CCC minimum package at BHC level**	Proportion of BHC that have the minimum package of IEC/BCC materials available for the Santénet technical areas: family planning and reproductive health (FP/RH), Integrated Management of Childhood Illnesses (IMCI), Nutrition, Malaria, STI/HIV/AIDS. "Available" means at least one copy on hand and on display at the time of verification.	Inventory and analysis of existing IEC/BCC health materials	MOH/FP's IEC and Social Mobilization Unit (IECSMU) contacted partners to send them existing IEC/CCC health materials. Now, materials are available at IECSMU	
			Identification of the contents of the minimum package based on above analysis	This task is on the priority agenda of Health Communication and Mobilization Committee (HCMC)	
			Updated materials or development of new IEC/BCC materials	Postponed to October 2005-April 2006	Due to reorientation of priority for the HCMC towards the development of the national FP communication strategy, to support the new National Family Planning Strategy.
			Development and implementation of distribution strategy for the BHC	Postponed to October 2005-April 2006	
8	**Number of communes in vulnerable biodiversity zones utilizing the *Kôminina Mendrika* [KM] approach that achieve health objectives**	Number of Communes in vulnerable biodiversity zones that obtain "Champion Commune" status, according to the same criteria defined in indicator 6. Vulnerable biodiversity zones are defined as those areas that are in, that surround or that directly affect protected areas – all communes that abut the forest plus all communes that influence the biodiversity through migration, high sales/demand for charcoal due to high population (peri urban or urban)	Definition and identification of vulnerable biodiversity areas according to SO6 team: "communes either abutting or indirectly affecting a protected zone"	Concept, tools and RFP developed in parallel with the KM approach (indicator#6)	
			Development of concept model and technical framework for Santénet Champion Commune approach.		
			Development of tools to implement the Champion Commune approach: social marketing kit; mass media/radio kit and interpersonal communication kit, including the trainer's guides for community-based agents		
			Development and circulation of request for proposal to partners for implementing the approach		
			Review of proposals and selection of partners for the implementation	11 communes identified during year one.	
			Development and signing of partner contracts	KM approach integrated health and environment implemented in 5 out of the 81 communes	
			Implementation of the approach in TBD communes defined as vulnerable biodiversity areas	Implementation of the integrated approach in other 6 communes under negotiation.	

Indicator number	Indicator	Definition	Planned		Actual	Comments
IR 2 : Increasing availability of selected health products and services						
9	Reduction in the number of stock-outs of injectable contraceptives at the health center level.	Percentage of BHCs reporting one stock-out of injectable contraceptives (Depo Provera) in the last 12 months. A "stock-out" is defined as the absence of a product that is supposed to be on hand at a given time.	12%		N/A	2005 FP Logistics Survey is ongoing (October 2005). The Result will determine whether the 12% objective is achieved or not
10	Functionality of the cold chain at the health center level	Percentage of BHCs with a functioning cold chain. A cold chain is considered "functional" if: - The temperature is monitored daily during last 6 months and the temperatures are in the range of +2°C and +8°C. - The stock of vaccine is sufficient until the next supply scheduled by the district level arrives (usually 1 month) Both criteria and their combination will be monitored.	Temperature monitored daily and in the range of +2°C and +8°C.during last 6 months	TBD	N/A	2005 VMA (Vaccine Management Assessment) is ongoing (November2005). Tendency of the Result will determine objectives for the next coming years.
			The stock of vaccine sufficient until the next supply scheduled by the district level arrives	TBD		
11	Santénet Champion Communes have an established distribution system for Social Marketing products	Number of Champion Communes having an established distribution chain for Social Marketing products. A complete chain of distribution means at least one Community Based Sales Agent trained and functioning in at least 75% of the fokontany. The functionality of CBS is measured by a least one request of restock during the KM cycle	Training of community sales agents in 80 communes involved in the KM approach		81 Kôminina established a distribution chain for malaria control, family planning, STIs/AIDS and diarrheal diseases prevention products.	
12	Number of Social Marketing products sold in Santénet Champion Communes	Number of Social Marketing products sold through the commune-level points of saleset up in the Champion Communes. Products include: Protector Plus®, Sur'Eau®, Pilplan®, Super Moustiquaire® and Palustop®	Training of community sales agents		43 trainers from 11 KM implementing NGOs trained. 1685 CBSAs trained in product distribution and health education techniques	
			Installation of community sales agents		1685 trained CBSA received a starting pack of the social marketing products (5 IMN, 20 Palustop blisters, 10 Sur'Eau bottles, 48 condoms Protector Plus and 10 Pilplan slabs)	

Indicator number	Indicator	Definition	Planned	Actual	Comments
13	**Proportion of curative consultations provided by BHC in Santénet Champion Communes**	The curative consultations measured by this indicator are the number of all new cases seen in the BHC compared to the total population covered by the BHC.	**TBD** 2004 average (Research in progress)	Research in progress.	
14	**DTCHepB3 coverage rate in remote populations of Santénet Champion Communes**	Proportion of children under 12 months living more than 5 km from a BHC, vaccinated in DTCHepB3 during advanced/mobiles strategies in the Santénet Champion Communes. The population living more than 5 km from a BHC is considered to be an underserved population because it is specifically targeted by the MOH/FP advanced strategies (mobile clinics).	**TBD** 2004 average (Research in progress)	Research in progress	Advanced / mobiles strategies data are difficult to gather
15	**Availability of social marketing STI treatment kits at the BHC level**	Percentage of health centers having at least one of the social marketing STI treatment kits **available** and **unexpired**. "Available" means an item that is in stock at the time of verification. The social marketing STI treatment kits are Cura 7® or Genicure®.	**TBD**	N/A	During the first year, Santénet was not able to implement activities supporting this indicator. In fact, PSI did not receive enough fund from the PMPS program to make Genicure et Cura7 available The World Bank, the ES/NACC, the MOH/FP and PSI are working together to address the problem.
IR 3 : Improving the quality of selected health services					

Indicator number	Indicator	Definition	Planned	Actual	Comments
16	**Policies, standards and protocols (PNP) in Santénet technical areas are updated**	Number of technical areas for which policies, norms, standards and protocols have been updated to meet international standards with assistance from Santénet, approved by the MoH/FP and disseminated. Policies, norms and protocols will be counted as a group for each priority area. "Updated" PNPS include those which have been revised to meet WHO eligibility criteria and the local context. The technical areas of Santénet are: Family Planning and Reproductive Hhealth (FP/RH), Integrated Management of Childhood Illnesses (IMCI), Nutrition, Malaria, STI/HIV/AIDS	3 technical areas having their PNP revised: STI/IHV/AIDS, malaria, FP/RH	- National child health policy revised and approved in September 2005 - Nutrition policy revised and approved in April 2005 - Malaria policy revised and awaiting approval. - Finalization of National RH policy expected to be completed in 2006 - National training policy document is in second draft form and work on it will continue until the end of 2005.	- RH policy revision process is ongoing with UNFPA support - Performance standards for FP, STI and prevention of malaria during pregnancy (PMP) developed and approved. This will help the revision of FP/RH norms and standards (August 2005)
17	**MOH/FP training curricula updated in each of the Santénet technical areas**	Number of curricula in the Santénet technical areas that are updated according to the revised national PNP, approved by the MoH/FP and used for pre-service and in-service training Technical areas of Santénet are: FP/RH, IMCI, Nutrition, Malaria, STI/HIV/AIDS	Adequacy assessed for the components related to the 3 technical areas in the curricula (STI/HIV/AIDS, Malaria, FP/RH)	Postponed	- The FP curriculum will be revised in November 2005 - Training modules for PCISE and AEN will be revised in 2006 - The malaria training module will be revised in 2006 with help from WHO and JHPIEGO as part of the MAC project.
18	**Performance standards achieved by practicum sites in Santénet intervention zones.**	Percentage of desired performance standards achieved by all practicum sites for the technical areas in Santénet intervention zones. The technical areas of Santénet are: FP/RH, IMCI, Nutrition, Malaria, STI/HIV/AIDS. The desired performance standards for three areas (STI/HIV/AIDS, Malaria and FP/RH) will be defined in the first year.	The desired performance standards in STI/HIV/AIDS, Malaria and FP/RH are developed	- Desired performance standards related to FP and STIs/HIV prevention defined. - desired performance standards related to FPC/MPP" defined.	
			The current performance level for these technical areas is assessed at the practicum sites	Assessment of current performance levels in the areas of FP/STI/HIV conducted in the 11 practicum sites	
			Action plans at practicum sites are implemented	Each practicum site has developed its action plan and implemented them	
19	**Percent of BHC meeting " Quality BHC " criteria in the champion communes**	Percentage of BHC certified "Quality BHC" in the Santénet champion communes A BHC is certified "Quality BHC" if it meets all of the following criteria: - has reached at least 40% of desired performance standards, as described	The desired performance standards for "Quality BHC" are developed in three areas (FP/RH, Malaria, and STI/HIV/AIDS)	The desired performance standards defined in September 2005 and awaiting approval	Introducing PQI to KMs will have to wait for its launch by the partners and for contracts to be signed with communes, which should be complete by November 2005. Adapting PQI approach for KM BHCs also required long process of review and this partly explains the delays
			PQI Training of service providers	Activity postponed for December 2005	
			The current performance level for these technical areas is assessed at the BHC level	The activity will start after the training of service providers on December 2005	

Indicator number	Indicator	Definition	Planned	Actual	Comments
		in indicator 18, - offers services in accordance with the standards and protocols updated within the Santénet technical areas, - where healthcare providers give appropriate counseling on contraceptive methods according to national guidelines, - where trained healthcare providers appropriately manage STI patients according to the syndromic approach.	Action plans are implemented by BHC	Activity postponed until February/March 2006	
IR 4 : Improving the institutional capacity To implement and evaluate health programs					
20	**BHC in Santénet champion communes produce quality monthly activity reports**	The quality of the RMA is defined by two parameters: - Completion according to the manual of procedure established by the SSSs (Service de Statistiques Sanitaires), that is the completion of the RMA and the correct use of the SIG tools - Accuracy of the reported data, verified by the validity of the equation proposed below According to the evaluation of SIS in 2005, the performance of the completion is already high (95 %). The correct use of the SIG tools will be tightly followed from Committees *Kôminina Mendrika* [*Santénet Indicator 6*]. So, the component of quality which will be followed in this indicator is **the accuracy reporting in the routine system** for two technical areas: Injectable contraceptives for FP and DTC-HepB for EPI	14%	14%	14% is a baseline was calculated for the BHC having reported FP data of the country in the Monthly Activity Report (MAR) via the SSSa (Service de Statistiques Sanitaires).
21	**Use of routine data in the commune level in Santénet champion communes**	Number of BHCs in Santénet champion communes using chartbooks as tool for decision-making in the past month. The "chartbook" is a graphic representation of BHC monthly data. It serves as a dashboard of indicators for the	Definition of chartbook contents and presentation Training of healthcare providers in the use of the chartbook	MOH/FP's buy-in to the "chartbook" concept has been secured. The tools are designed and ready for field test Postponed on October 2005	The slight delay in the GIS analysis has affected planning for other activities to implement the chartbook in communes involved in KM.

Indicator number	Indicator	Definition	Planned	Actual	Comments
		BHC which displays a monthly action plan according to changes in the BHC indicator values. The diagrams will be shared on a regular basis with local authorities in order to include them in decision-making regarding health promotion in the commune. The BHC "uses" the chartbook as tool of decision-making when: - the data are posted and updated in the BHC on a monthly basis - the Communal Development Plans (PCD) incorporate the BHC health data	Implementation of the chartbook in **80** champion communes	Postponed (will be effective after Training of healthcare providers)	

CHAPTER EIGHT

ADMINISTRATION AND OPERATIONS

The administration and operation section of this report also covers the start-up period from June 2004 to September 2004, and also describes the activities related to the Santénet Fund.

2004-2005 ACHIEVEMENTS

Rapid project start up

- Set up and equipped main project office and established operation and management systems within 90 days of award
- Set up and equipped four regional offices in Toamasina, Fianarantsoa, Toliara and Fort Dauphin

Strengthened staffing

- In order to better meet the needs of Santénet's clients and partners, the project staff has expanded to 57 percent more staff than anticipated in the project proposal. Current staffing includes 23 long-term professionals, 14 administrative/financial support staff, eight drivers and two janitors. We have five expatriate staff: three long-term professionals from Chemonics International, one from JHPIEGO, and one from Michigan University.
- A Memorandum of Understanding with the Peace Corps facilitated the assignment of three Peace Corps volunteers to provide additional technical and managerial support to our regional offices of Toamasina, Fianarantsoa and Fort Dauphin.

Compliant and standardized financial, management and administrative systems

- Chemonics' previous LDI project's policy and procedures manual was updated to meet the project's specific needs. All Chemonics-managed projects in Madagascar are now employing the same policy and procedures manual.
- The accounting software was set up by the home office field accountant who also trained the local accounting staff.
- With USAID approval, the number of project CLINs was reduced from five to four. See below for the table of expenditures by CLINs as of September 30, 2005.
- A second table gives the expenditures by source of funding as of September 2005.

Productive, cost-effective administrative relationships with other projects

- Santénet shares regional offices with its partners: CARE in Toamasina, MCDI in Toliara, ERI/DAI in Fianarantsoa and MISONGA/PACT in Fort Dauphin, which solidifies our relationship with our partners and other CAs, as well as represents a cost savings to the project.
- The administrative teams of the Ecoregional Alliance closely collaborated to ensure standardization in *per diem* policy for private and public partners.
- In Fianarantsoa we are sharing ERI's specialized internet connection for

more efficient, cost-effective internet access.

State-of-the-art information and communication technology

- The Santénet office in Antananarivo has a dedicated connection for Internet access, several telephone lines and a fleet subscription from a cellular phone company.
- Our regional offices have Internet access through local providers, land phone lines and cellular phones.
- Santénet procured five generators (three for main office and one for Fort Dauphin and Toliara) to assure consistent power supply in the face of increasingly erratic sources of electricity.

Refer to the annexes for details about expenditures as of September 30st, 2005, and eExpenditures by source of funding as of September 30, 2005.

LOOKING AHEAD

With the staff roster now complete and all offices opened as projected for Santénet's first year, the second year of operations will see continued assessments of administrative/communication systems and an update as necessary to ensure they are responsive and assist with the efficient performance of the project.

CHAPTER NINE

THE SANTÉNET FUND

During 2004 and 2005, Santénet initiated the Champion Commune community mobilization approach to improve health indicators related to child survival, reproductive health, and family planning in target communes by contracting or granting to local and international NGOs to implement KM in selected communes.

Publishing the request for proposals. Santénet pre-selected 12 partners for the implementation of the Champion Commune approach. These include eight national NGOs (ASOS; SAF-FJKM; SALFA; and Voahary Salama members AINGA, MICET, MATEZA and Ny Tanintsika) as well as four international organizations (ADRA, CARE. CRS, and MCDI) The request for proposals document that was released on February 18, 2005 included a request for candidature for local NGOs and a request for proposal for private voluntary organizations; the terms of reference of the Champion Commune approach; a proposal format; a table of activities format; and a budget format. A standard grants manual has been prepared by the homeoffice, was submitted to USAID in February 2005 and approved by the Contracting Officer on March 8, 2005.

Receiving proposals. Santénet received 12 proposals with an initial total budget of US$1,400,000 to implement the approach in 75 communes in the provinces of Toamasina, Fianarantsoa, Toliara and Antananarivo. Local NGO Voahary Salama was also contracted to provide technical assistance and organizational development assistance to its member organizations (AINGA, MICET, NyTanintsika and MATEZA).

Assessing the proposals. The proposals were reviewed by Santénet's internal Champion Commune commission, which was composed of the project director, the regional programs coordinator, the finance and administrative director, and the grants manager. The commission members critiqued the proposals based on the terms of reference; reviewed the financial proposals, with special consideration to cost eligibility criteria outlined in the RFP document; and identified issues in the technical and financial proposals that required further discussion. In parallel with the technical review and negotiation process, visits to the partners' headquarters were made to verify their programmatic, financial, and administrative management skills and capacities. At the end of the review, the commission summarized the issues requiring clarification and posed a series of written questions to the offerors.

Revising proposals. Pursuant to the clarification questions, technical meetings were organized with partners in April 2005 to discuss and negotiate elements to be considered in the final proposals. As a result of much negotiations, the total budget was reduced to US$911,562, while the number of communes increased to 81 (80 rural and 1 urban).

Finalizing and signing contract documents. Upon receipt of the revised, final proposals, Santénet finalized the contract documents. The whole process between the release of the RFP/RFA on Feburary 18, 2005 until the signature of the first subcontracts and grants on June 3, 2005, took four months.

Three subcontracts and three grants were signed in June 2005. The four

grants with the Voahary Salama NGOs were signed in August 2005, as well as a fourth subcontracts for the implementation of Tanàna Mendrika in the town of Ft. Dauphin. Finally, an additional grant for one commune was signed in September 2005. Refer to annexes for more details about these grants and subcontracts.

As of September 30, 2005, Santénet has four subcontracts with the international PVOs and eleven grants with the national NGOs for a total of 81 communes. The communes are distributed as follows:

1. ADRA: 8 communes
2. CARE: 11 communes
3. CRS: 8 communes
4. MCDI: 10 communes
5. ASOS : 18 communes (Breakdown: ASOS Central: 10 communes; ASOS South: 8 communes)
6. SAF-FJKM: 9 communes
7. SALFA: 4 communes
8. AINGA: 4 communes
9. MICET: 2 communes
10. Ny Tanintsika: 3 communes
11. MATEZA: 4 communes

SANTENET 2005

Left: Santénet's Chief of Party shaking hand with the Director of ASOS Central

Right: Santénet's Chief of Party and Catholic Relief Service's Director during the signing ceremony of the subcontract.

SANTENET 2005

CHAPTER TEN

BEST PRACTICES AND LESSONS

Santénet's first year of implementation was accompanied by an significant learning curve. This section details some of the more important lessons learned during the first year — what worked and what didn't work and why. These lessons will inform the project's future activities.

PROMOTING PARTNERSHIP: THE RIGHT WAY TO CREATE SYNERGY

During this first year, Santénet has proven that the institutionalization of the partnership, the exploration of consensus among different partners for decision making, and the search for synergy among stakeholders constitute an important condition for success and for sustainability. This lesson has important implications for the project's interventions in the future, that is, making sure decisions and responsibilities are shared with the other partners and mutual concerns and benefits are considered. Following are some examples of Santénet activities that confirmed the importance of the promotion of partnership:

1. The HCMC mobilized different government departments, under the leadership of MOH/FP and the Ministry of Communications. The private sector and NGOs were closely involved and take real responsibilities for the next steps.

2. The development of the National FP communication strategy mobilized different partners in the analysis of the strengths and weaknesses of the current activities and in the identification of innovative approaches, implying the contribution of each stakeholder.

3. The implementation of the religious leaders' platform for FP and STI/AIDS was done in a participative process, allowing the different entities to identify the opportunities of interventions. The ES/NACC recognized the importance of the role of religious leaders in promoting safer behaviors and helping prevent the spread of epidemics. Within this platform where their roles are formally identified, religious leaders are much more actively involved.

4. By promoting partnerships, it is possible to leverage technical assistance and funding. For example, UNICEF financed the training of health agents cold chain system planned in Santénet's Year 1 work plan, and UNFPA decided to fund the literary review necessary for the development of the national FP communication strategy that was to be funded by Santénet.

BUILDING ON THE PREVIOUS SUCCESSES: KEY FACTOR FOR CONTINUATION

One of the most important factors for the success of this first year was the fact

that Santénet did not reinvent the wheel. All of the activities were based on the achievements of the previous strategies and involved existing structures.

This approach allowed the project to move quickly forward and to anticipate long-term continuation. Here are some examples:

1. The *Kôminina Mendrika*, or Champion Commune, approach is basically the expansion and scale up of the Champion Communities approach designed, tested and developed during previous USAID health projects in Madagascar.

2. The development of the National FP Communication Strategy started by comparing the results of 1997 DHS and 2003 DHS in terms of communication. The identification of key interventions was based on the reorientation of previous interventions to the new context.

3. Santénet helped the MOH/FP create a core group of master trainers. The members were first trained in clinical training competencies and then training was reinforced with "Advanced Training of Trainers": they represent national resources and will help train facilitators to roll-out PQI.

4. The regional health district teams who were in the first group trained in PQI for the 11 practicum sites will be members of the evaluation team. They will ensure the introduction of PQI at the health centers of Champion Communes.

5. The region of Fianarantsoa has had remarkable experience with *mutuelle*s. Santénet helped MOH/FP use lessons learned from these experiences to develop broad, national strategies for decreasing financial barriers to health care.

OWNERSHIP BY NATIONAL ENTITIES: AN EARLY STEP TOWARDS SUSTAINABILITY

Santénet aims to provide sustainable models of development for Malagasy institutions. The leadership, commitment and ownership of the Government from the conceptualization of Santénet's approaches and the development of different tools are key factors for the success of the project. The enthusiasm and the support from MOH/FP staff and key government partners such as the ES-NACC express commitment at the highest level of government. This receptivity facilitated Santénet's productive working relationship with the various levels of public health system, as well as with the activities themselves. Santénet's key approaches (KM, PQI, Ankoay, Equity Fund) have been integrated into national development strategies:

1. The Champion Commune approach is recognized as a multisectoral development platform at the Commune level. The Ministry of Decentralization's Monitoring and Evaluation Department in charge of the development of communes is currently developing performance measurement tools using most of KM objectives/indicators. . At the local level, the majority of mayors in KM communes have expressed interest in adding environment, economic growth and good governance activities to Santénet's health objectives and interventions.

2. The PQI (Performance and Quality Improvement) approach, developed with the MOH/FP is recognized by key partners such as UNICEF and WHO as a model of direct participation of health care providers, by providing a method of self-evaluation and a participatory identifying themselves feasible ways of improving the quality of care.

3. Santénet's promotion of data for decision-making has been adopted by the MOH as the basis of monitoring programs and activities. Information from health centers is shared with local stakeholders, allowing them to participate and intervene accordingly. This is not only a way to encourage transparency in decision-making, it encourages resource allocation based on the demonstrated needs of a population.

4. The Ankoay approach used with scouts is accepted by the Executive Secretary of the National AIDS Control Committee (ES/NACC) as an effective and convenient way of involving young people in the fight against HIV/AIDS. The approach is currently being adapted by

ES/NACC to other settings, such as sport federations.

LEARNING BY DOING: KEY CONDITION FOR INTEGRATION

By attentively listening to its partners and being flexible to the changing context in Madagascar, Santénet has learned as it went along, proving flexibility, demonstrating innovation and showing results in the process. The following examples show how Santénet has learned from its own activities; how it has shared the lessons to other partners and has adapted its work plan, activities and approaches according to changing priorities and the state-of-the-art thinking:

1. Santénet's partner ERI has shown its interest in piloting the integration of health and environment interventions. In collaboration with Santénet, ERI technicians developed indicators and designed integrated approaches. Both organizations are pooling resources and expertise to implement the integrated approach in five communes in the Toamasina Province, with plans to expand to another six in the province of Fianarantsoa.

2. In its current design, the *Kôminina Mendrika* approach fits with a rural setting. The mayor of Fort Dauphin and the Region Chief of Anosy were willing to develop an urban version: Santénet responded and helped them develop the "*Tanàna Mendrika*" approach to address the health issues particular to an urban setting.

3. Santénet has increasingly realized the power of mass media, namely rural radio stations, and has adapted its KM approach to dedicate special efforts and resources to this important communication channel.

4. During the development of National FP strategy, one of the most important interventions identified by the MOH/FP partner was the use of community-based sales agents (CBSA). Santénet developed a Statement of Collaboration with PSI to expand the network of CBSA in the KM sites.

5. Finding the right methodology for defining and measuring KM health objectives was particularly difficult, but after discussions with different partners, a consensus was reached. In fact, all of the data sources present weaknesses: surveys are expensive and cannot be feasibly carried out on a frequent basis; routine data generally are not considered as reliable. The technical group, formed by the MOH technical staff, Santénet and its implementing partners, recommended using routine data to measure project/commune progress against objectives, and using national surveys to measure the project's larger public health impact. This compromise shows the interest of combining technical expertise and the use of lessons learned from field activities.

FLEXIBILITY AND ADAPTATION TO THE CHANGING CONTEXT: SYMBOL OF WILLINGNESS TO PROGRESS

One of Santénet's major strengths in its first year was its capacity to adapt to a changing environment, its reactivity and its flexibility for resource reorientation has allowed it to capture momentum for new ideas and approaches and allowed it to dispense with activities which are no longer relevant.

1. The dismantling of the Mobile Sanitary Team (ESM) resulted in Santénet having to cancel all its planned activities which should be led by this entity. Santénet reoriented the use of the resources towards more productive interventions such as the development of *mutuelles* schemes and the supply of management tools for EPI.

2. The constraints on the availability of some health products did not eliminate Santénet interventions, but required some modifications:

- At the national level, Cura-7 and Génicure were not available in time. Therefore, planned interventions aimed at increasing the availability of these products could not be carried out for the public sector. Nevertheless, the activities supporting the distribution chain of

the public sector led to the increased availability of the other health products such as contraceptives and essential drugs.

- Santénet planned to help with the distribution of socially marketed ITNs but the available quantity was insufficient with regard to the needs. However, in close collaboration with PSI, Santénet kept developing the community based system for the distribution of any socially marketed product. CBD agents currently are distributing contraceptive products (including condoms), Sûr'Eau and some ITNs. This means that when additional ITNs or other new socially marketed products are available, the CBSA will already have the capacity to ensure their distribution. For next year, the MOH is planning to introduce Artemisinin Combined Therapy for Malaria treatment and community-based treatment of pneumonia by Cotrimoxazole. With some specific training and support, the MOH agreed to use Santénet's partner NGO's CDBA as entry point to these innovative approaches.

3. At the beginning of the year, Santénet had problems identifying a PQI liaison within the Faculty of Medicine and defining areas for collaboration, but discussions and perseverance finally achieved good results. In fact, through advocacy and periodic consultation meetings with key actors of the training institutions, the Santénet team was able during the last quarter of the year to identify activities and develop an action plan. Activities are planned for the last quarter of 2005 and for 2006 to improve the training skills of instructors; revise the IIMM training curriculum and to reinforce the coaching system at the internship sites

4. The Voahary Salama team could not be as closely involved as expected during the launch of the planned activities because of organizational restructuring. Santénet responded by signing grants directly with the VS member organizations, while retaining VS involvement through an umbrella grant for TA, OD and monitoring. This meant that KM could continue apace, while VS' TA role was maintained.

CHAPTER ELEVEN

THE FUTURE

For the period of October 2005 to September 2006, Santénet has planned the following activities. For more detailed information, please refer to the Santénet annual work plan for 2005-2006.

Pursuing the scaling up of the Kôminina Mendrika approach. Scaling up the KM approach will widely contribute to improving maternal, child, and family health in the intervention zones. The KM approach fosters and promotes community participation to manage its own health. Therefore, Santénet will scale up the KM approach to reach the objective of involving 300 communes by the end of the project in 2008. Santénet and its 11 partner NGOs will complete the first KM round in 81 communes, with a special effort to increase the private sector's involvement, before entering the second round and initiating the approach in 100 additional communes. Meanwhile, Santénet will explore a more streamlined implementation model for KM in order to reduce costs and to facilitate a rapid scaling up and long-term sustainability. Santénet will continue working with ERI to implement the health-environment integrated approach in priority biodiversity conservation areas.

Implimenting the Tanàna Mendrika (Champion Town) approach. While the IR 1 team's activities have been focused in rural areas to date, urban areas are also faced with the same health problems and often at greater intensity due to high population density. Recognizing that mobilization strategies and the IEC/BCC activities need to be adapted for the specific characteristics of target groups and the existence of specific communication channels in urban settings, an adapted KM approach is needed to mobilize and raise awareness in urban populations. The *Tanàna Mendrika* (TM) approach will be an urban adaptation of the *Kôminina Mendrika* approach for community mobilization, and Santénet plans to pilot it in Fort Dauphin.

Supporting the Health Communication and Mobilization Committee (HCMC). During the process of developing BCC/IEC tools for the Champion Commune approach, Santénet set an example to other HCMC members by having its materials validated by the committee before production. As a result, Santénet's materials development process (designing and testing samples using focus groups before having them validated by the HCMC) has been adopted as a standard by several partner institutions. For this reason, it is important to continue supporting HCMC so that this platform becomes the only mechanism for validating IEC/BCC materials, which will ensure coordination of national social and community mobilization efforts. As the appointed secretary of the committee, Santénet will continue backing the IECSMU in ensuring the HCMC operations. The project will also continue playing an active role in the FP sub-committee and will encourage members, including the MHO/FP's Family Health Division (FHD) and UNFPA, to develop and implement a national communication strategy for FP by the end of the year.

Launching Child Health Week. The effectiveness of this approach has been demonstrated in several countries such as Morocco, Burundi, and Haiti. For several years now, Madagascar has been organizing different mass campaigns throughout the year, such as national immunization campaigns, vitamin A

distribution, deworming campaigns, and polio vaccinations. These campaigns have proved to be effective in mobilizing rural and urban households, evidenced by the high coverage rates achieved. However, costs related to mobilization and logistics under these campaigns are quite high. Thus, it would be interesting to explore the feasibility of establishing Child Health Weeks once or twice per year, during which all the services are provided within the week. In a first stage, Santénet will advocate this approach among the MOH/FP and its partners. If MOH/FP and its partners are favorable to the concept, Santénet will assist in raising public awareness for the first Child Health Week.

Reinforcing youth mobilization for HIV/AIDS prevention. To date, the Ankoay approach project has proved effective in mobilizing young people in HIV/AIDS control. For this reason, Santénet will continue supporting the project, mainly in launching the second phase with scouts, and in adapting the Ankoay approach to target young sportsmen and sportswomen.

Reinforcing partnerships. The IR 2 team intends to reinforce and follow up the different partnerships to operationalize the various partnerships established this year, including the FP/RH partnership, RBM for malaria, and the interagency-coordinating committee (IACC) for EPI. In addition, support to the financing committee for the coordination of health programs appears among the challenges of this year.

Reinforcing the public and private sector supply chains. In addition, IR 2 will focus upon all activities relating to improved access to health products and services, in the public and private sectors: support to the supply chain for FP, GED, EPI, socially marketed products, and other health products, extension of service delivery, and capacity building for the health system.

Supporting the Ministry of Health and Family Planning as it finalizes its policy updates and RH/FP standards and protocols revision. Additional support from UNFPA, UNICEF and WHO will help make this effort a reality. Given that the PSP development/update process will take time, Santénet, in cooperation with MOH/FP and the MAC project, developed interim desired performance standards in RH/FP, STI and CPC/PMP, which have been accepted by the MOH/FP and have allowed the introduction of the PQI approach at 11 practicum sites. Creation of these standards will speed up the process of updating the standards and protocols in these three specific areas. In 2006, Santénet will also support the development of desired performance standards for child health to facilitate the introduction of PQI in child health in KM communes.

Providing support to continuing education of service providers. To support continuing education of service providers, Santénet will help a group of master trainers to standardize and update their knowledge in the identified technical areas. All of these trainers will be used to update/train service providers at practicum sites and the CBHCs in KM communes. This will give the MOH/FP a core group of master trainers at the national and regional level who are qualified and competent to train in IP, FP/STI/HIV, and CPC/PMP. In turn, trained service providers will be capable of providing high-quality services. In this way, Santénet will be able to meet the service provider training/updating needs in the CBHCs in the KM communes, in terms of contraceptive technology, syndromic management of STIs, supportive supervision and FP/STI/HIV counseling.

Providing support to pre-service training. For pre-service training, the introduction of PQI enabled the 11 practicum sites to identify common training needs in contraceptive technology, syndromic management of STIs, supportive supervision and FP/STI/HIV counseling. To help meet these needs, Santénet will organize training and refresher workshops. To improve the quality of these training sessions, Santénet will make available updated teaching materials and mannequins for students. Santénet will also support an update of the IMCI (integrated management of childhood illness) and ENA (essential nutrition actions) training modules for the PTIs, refresher of the decision-making algorithm for classification and treatment, and adaptation/development of an IMCI workbook. Professors at the faculties of medicine will be trained in effective teaching methodology for IMCI, and the PTI monitors will be trained as trainers, as well as in the use of updated IMCI

guides, and in essential nutritional actions. In addition, the training institutions and the MOH/FP will receive support to revise the hospital training program in emergency obstetrical and neonatal care (EONC). This will be done by updating the key stakeholders in EONC, developing desired performance standards for EONC, and updating the EONC training curriculum. All agents trained during these sessions will be periodically supervised to ensure that the knowledge acquired is correctly applied.

Following the PQI approach in practicum sites. With regard to improving the quality of service delivery, the IR 3 team, in cooperation with the site supervisors, the MOH/FP/DHS and the regions will follow up, with STTA from JHPIEGO, on the implementation of the PQI action plans at the 11 practicum sites and will periodically evaluate the progress made in applying standards.

Scaling up the PQI approach in KM communes. PQI expansion will occur at the CBHCs level in the KM communes. High-performing CBHCs will be given the title "Quality CBHCs" through a certification process. In these health facilities, IP, FP, STI, CPC/PMP and child health will be an integral part of the PQI approach. The second-year interventions will allow Santénet to improve KM implementation, ultimately contributing to improved nutritional and child health services and increasing the use of FP/STI and PMP services.

Scaling up the SDM pilot study. The team will continue to follow up on the SDM pilot study and, in cooperation with the Institute for Reproductive Health (IRH) of Georgetown University and the MOH/FP, will organize an evaluation of the results achieved in 2005 with a view to scaling-up the program.

Reinforcing the health system. In order to reinforce the health system, Santénet will support the MOH/FP in updating the HMIS management tools and strengthening the capacities of the regional health services (RHS) in HMIS, establishing the national SIS policy, reinforcing communes for better use of health data and sharing health information.

Improving NGOs capacities. To improve the capacity of NGOs, Santénet will aid the MOH/FP to implement the National Contracting Policy for Health. In this same framework, Santénet will help the MOH/FP establish and operationalize the FP partnership and it will facilitate NGO partners' ability to implement KM approach. Some STI/AIDS prevention activities included in IR 4 also support NGOs, namely helping the ES/NACC organize thematic working groups to establish a common vision and facilitate communication among those involved in the fight against STI/AIDS. Similarly, Santénet will monitor the application of the STI guide in collaboration with ES/NACC as well as the public sector.

Reinforcing civil society's capacity to better advocate for health. To reinforce civil society capacity to better advocate for health, Santénet will support the religious leaders' platform in the implementation of a program to support the new FP and HIV/AIDS strategies.

ANNEXES

ANNEX 1. ACTIVITES IR 2 – IR 4: BREAKDOWN OF SANTÉNET-SUPPORTED TRAINING BY THEME, NUMBER AND GENDER OF PARTICIPANTS

Priority programs	Topics	Gender		Levels of interventions	Partners	Number of workshops/ sessions
		F	M			
FP, CH, STI Malaria	CBSA TOT for doctors	29	26	- National	- PSI - 11 NGOs	6
FP, CH, STI Malaria	CBSAs training	957	858	- Communes	- 11 NGOs	89
R.S.S	BHC Management committees for healthcare providers and local authorities	242	198	- Communes	- Min San/PF - Community	12
R.S.S	Dissemination of DHS results for regional and national decision makers, regional and district health officials and local authorities	501		- Region	- Min San/PF - UNFPA - World Bank - Health Region	9
R.S.S	Introduction to *mutuelle* (Talatan' Ampano) for healthcare providers, company manager and the community	44	55	- Commune	- Min San/PF	1
FP	FP program management for regional and district health officials, PHAGEDIS NGOs	171	73	- Province	- Min San/PF - NGOs	7
FP	PIPELINE software orientation for FP program managers	5	5	- National	- Min San/PF - USAID - PSI - UNFPA - SALAMA	1
FP	Introduction to the training in FP product management for district managers	9	1	- District	- MOH/FP	3
EPI	EPI program management for regional program managers	15	83	- Region	- Min San/PF - WHO - UNICEF	8
EPI	National TOT for EPI supervisors	12	6	- National	- Min San/PF - WHO - UNICEF	1
STI	STI guide for facilitators, community leaders and local outreach workers	100	78	- Province	- National NGOs - Local NGOs - Min San/PF - HIV/Alliance	7
TOTAL	***(Dissemination of DHS results not included)***	1584	1383	-	-	

A total of 1584 women at least, i.e. 53 percent of participants received training.

ANNEX 2. LIST OF PILOT HEALTH CENTERS FOR THE STANDARD DAYS METHOD

ADRA	CRS	SAF/FJKM	SALFA	MOH/FP
CHRP Toamasina BHC II Ankirihiry BHC II Ambohijafy BHC II Tanambao I BHC II Dépôt Analakininina	Clinics AMCM: Imerintsiatosika Namehana Analamahitsy Mangasoavina Maternité Ave Maria Antsirabe	Clinics ISALAMA: Ambatolampy Ambalavao Ambohimangakely HAVOZO Faravohitra Analakely	Hospitals SALFA : Andranomadio/Antsirabe Ambohibao/Tànanarive Dispensaires SALFA : Fandriana/Fianarantsoa Ambohimandroso Gara 67 Ha Antananarivo	BHC II Tsaralalana BHC II Isotry central BHC II Itaosy BHC II Ambohimanambola BHC II Ambohimalaza

ANNEX 3. EXPENDITURES AS OF SEPTEMBER 30, 2005

Lignes budgétaires	TOTAL BUDGET	CLIN 1			CLIN 2			CLIN 3			CLIN 4			CLIN 5 Inactive
		BUDGET	EXPENDITURE	REMAINING	BUDGET	EXPENDITURE	REMAINING	BUDGET	EXPENDITURE	REMAINING	BUDGET	EXPENDITURE	REMAINING	EXPENDITURE
1 SALARIES	2,346,992.73	645,879.00	162,477.68	**483,401.32**	703,814.89	218,468.01	**485,346.88**	532,918.00	127,244.62	**405,673.38**	432,894.00	165,652.71	**267,241.29**	31,594.09
2 FRINGE	782,373.32	217,011.00	44,413.59	**172,597.41**	233,252.00	52,707.15	**180,544.85**	182,188.00	36,060.22	**146,127.78**	137,864.00	43,254.45	**94,609.55**	12,058.32
3 OVERHEAD	1,732,198.13	478,468.00	107,895.16	**370,572.84**	522,139.00	147,004.15	**375,134.85**	394,289.00	83,485.78	**310,803.22**	313,764.00	110,036.77	**203,727.23**	23,538.13
4 TRAVEL & TRANSPORTATION	326,097.40	82,902.00	44,186.73	**38,715.27**	91,486.00	62,378.88	**29,107.12**	80,171.00	40,136.90	**40,034.10**	53,938.00	39,254.46	**14,683.54**	17,600.40
5 ALLOWANCES	701,658.00	189,828.64	57,912.79	**131,915.85**	206,359.00	63,934.09	**142,424.91**	170,478.00	43,632.80	**126,845.20**	122,554.00	43,235.38	**79,318.62**	12,438.36
6 OTHER DIRECT COSTS	1,687,445.00	448,424.60	79,513.49	**368,911.11**	496,494.97	79,020.54	**417,474.43**	432,410.00	74,977.30	**357,432.70**	292,362.00	73,684.47	**218,677.53**	17,753.43
7 EQUIPEMENT, VEHICLES & FREIGHT	299,470.00	64,277.00	73,772.56	**-9,495.56**	69,789.14	75,759.84	**-5,970.70**	60,584.00	71,785.31	**-11,201.31**	41,237.00	65,823.49	**-24,586.49**	63,582.86
8 TRAINING	1,736,787.59	464,531.00	102,968.17	**361,562.83**	514,848.00	179,234.65	**335,613.35**	452,284.00	69,525.19	**382,758.81**	303,380.00	40,161.47	**263,218.53**	1,744.59
9 SANTENET FUND	2,000,000.00	535,435.00	192,411.64	**343,023.36**	593,476.00	0.00	**593,476.00**	521,380.00	0.00	**521,380.00**	349,708.00	0.00	**349,708.00**	0.00
10 SUBCONTRACTS	3,410,522.70	436,640.00	66,682.29	**369,957.71**	1,029,922.00	135,283.45	**894,638.55**	1,218,081.00	396,052.06	**822,028.94**	695,218.00	233,022.22	**462,195.78**	30,661.70
SUBTOTAL	**15,023,544.87**	3,563,397.24	932,234.10	**2,631,162.14**	4,461,581.00	1,013,790.76	**3,447,790.24**	4,044,783.00	942,900.18	**3,101,882.82**	2,742,919.00	814,125.42	**1,928,793.58**	210,971.88
11 G&A	600,942.00	142,490.00	40,335.57	**102,154.43**	178,388.00	44,973.79	**133,414.21**	161,654.00	42,183.62	**119,470.38**	109,865.00	36,363.74	**73,501.26**	8,439.00
12 FIXED FEE	931,344.13	220,329.00	58,028.82	**162,300.18**	275,411.00	62,899.61	**212,511.39**	248,037.00	58,708.82	**189,328.18**	174,427.00	50,622.38	**123,804.62**	13,140.13
TOTAL	**16,555,831.00**	3,926,216.24	1,030,598.49	**2,895,616.75**	4,915,380.00	1,121,664.16	**3,793,715.84**	4,454,473.00	1,043,792.62	**3,410,681.38**	3,027,211.00	901,111.54	**2,126,099.46**	232,551.01

ANNEX 4. EXPENDITURES BY SOURCE OF FUNDING AS OF SEPTEMBER 30, 2005

Source of funding	Total Budget	IR1	IR2	IR3	IR4	IR5	TOTAL Expenses	Remaining budget
Family Planning	$ 5,903,830.00	207,284.42	$ 411,541.78	$ 346,660.88	$ 155,031.90	$ -	**$ 1,120,518.98**	$ 4,783,311.02
Primary causes of mortality and morbidity	$ 4,085,211.00	$ 420,220.66	$ 409,717.80	$ 316,212.60	$ 321,361.40	$ -	**$ 1,467,512.46**	$ 2,617,698.54
Polio	$ 300,000.00	$ 9,531.70	$ 44,762.20	$ 13,235.14	$ 11,671.25	$ -	**$ 79,200.29**	$ 220,799.71
Micro-nutrients	$ 1,240,000.00	$ 41,939.49	$ 142,188.70	$ 58,234.63	$ 51,353.52	$ -	**$ 293,716.34**	$ 946,283.66
Infectious disease/Malaria	$ 1,915,000.00	$ 151,720.50	$ 104,395.49	$ 172,645.07	$ 156,101.73	$ -	**$ 584,862.79**	$ 1,330,137.21
HIV/AIDS	$ 3,111,790.00	$ 102,272.38	$ 59,430.16	$ 186,507.94	$ 208,668.29	$ 232,551.00	**$ 789,429.77**	$ 2,322,360.23
TOTAL	**$ 16,555,831.00**	**$ 932,969.15**	**$ 1,172,036.13**	**$ 1,093,496.26**	**$ 904,188.09**	**$ 232,551.00**	**$ 4,335,240.63**	**$ 12,220,590.37**

ANNEX 5. EXPENDITURES BY SOURCE OF FUNDING AS OF SEPTEMBER 30, 2005

Beneficiary	code	Number of communes	Names of the communes	Date of signature	Total amount	Disbursement to date	Remainder	Activities to be funded by the disbursement
Subcontract								
CARE	CTR-001	10	Vohilengo, Ampasimbe Manantsatrana, Ampasina Maningory, Tsivangiana, Amboditavolo, Mahela, Betsizaraina, Ambodiharina, Tsaravinany, Masomeloka	3-Jun-2005	188,124,049.76	37,624,809.95	150,499,239.81	chronogramme détaillé
CRS	CTR-002	8	Mahatsara Sud, Tsaravary, Andonabe, Anosimparihy, Kelilalina, Tsiatosika, Antsenavolo, Ifanadiana	14-Jun-2005	144,322,800.00	0.00	144,322,800.00	
ADRA	CTR-003	8	Anosibe An'ala, Belavabary, Amboasary, Ampasipotsy Gara, Anosibe Ifody, Vodiriana, Ambohidronono, Antanandava	13-Jun-2005	185,629,657.00	30,938,276.00	154,691,381.00	chronogramme détaillé
CARE	CTR-004	1	Fort-Dauphin	25-Aug-2005	97,459,704.00	19,491,941.00	77,967,763.00	chronogramme détaillé
Grant								
ASOS CENTRAL	SPG-001	6	Brickaville, Mahatsara, Ranomafana, Ambila, Bemanonga, Mandoto	14-Jun-2005	141,082,800.00	35,270,700	105,812,100.00	avance de démarrage
ASOS FORT DAUPHIN	SPG-002	8	Ifarantsa, Manambaro, Ankaramena, Ranopiso, Ankariera, Tanandava, Beheloka, Itampolo	14-Jun-2005	189,969,700.00	47,492,425.00	142,477,275.00	avance de démarrage
SAF FJKM	SPG-003	8	Antentezambaro, Andasibe, Ambatovola, Beforona, Ilafy, Ambanitsena, Tsiafajavona, Marosoa	14-Jun-2005	183,513,236.00	45,878,309.00	137,634,927.00	avance de démarrage
MATEZA	SPG-004	4	Manakambahiny Est, Antanandava, Ambodimangavalo, Amparihitsokatra	2-Aug-2005	99,583,380.00	24,895,845.00	74,687,535.00	avance de démarrage
TANINTSIKA	SPG-005	3	Miarinarivo, Sendrisoa, Vohitsaoka	2-Aug-2005	77,490,900.00	19,372,725.00	58,118,175.00	avance de démarrage
AINGA	SPG-006	4	Antaretra, Tsaratanàna, Ambohimiera, Ranomafana	2-Aug-2005	79,989,800.00	19,997,450.00	59,992,350.00	avance de démarrage
MICET	SPG-007	2	Tolongoina, Ikongo	2-Aug-2005	48,678,250.00	12,169,562.00	36,508,688.00	avance de démarrage
VOAHARY SALAMA	SPG-008		Assistance technique	2-Aug-2005	190,953,000.00	47,738,250.00	143,214,750.00	avance de démarrage
SALFA	SPG-009	4	Sahambavy, Androy, Talatan'Ampano, Ambalakely	8-Aug-2005	100,002,230.00	25,000,557.00	75,001,673.00	avance de démarrage
ASOS CENTRAL	SPG-010	4	Anivorano Est, Andranobolahy, Ambodilazana, Morarano Gara	30-Aug-2005	70,149,100.00	17,537,275.00	52,611,825.00	avance de démarrage
SAF FJKM	SPG-011	1	Anjeva Gara	30-Sep-2005	26,175,444.00	0.00	26,175,444.00	